STATE CHILDREN'S HEALTH INSURANCE PROGRAM ADMINISTRATION

(NC HEALTH CHOICE PROGRAM FOR CHILDREN)

Joint Report of the
Department of Health and Human Services, Division of Medical Assistance
and the
North Carolina State Health Plan

to the
North Carolina General Assembly
Legislative Committee on Employee Hospital and Medical Benefits

FEBRUARY 2008

Table of Contents

I. Executive Summary

During the 2007 Regular Session, the General Assembly enacted legislation to study administration of the NC Health Choice program to ensure a smooth and effective transition in light of the phase out and replacement of the Teachers' and State Employees' Comprehensive Major Medical (CMM) Plan (i.e. the indemnity plan) with a preferred provider organization (PPO) effective July 1, 2008. The legislation was enacted to help ensure NC Health Choice, which is benchmarked to the CMM by state law (i.e. Health Choice coverage is required to be substantially equal to coverage provided to dependents of teachers and state employees), does not experience a disruption in access to care, quality of medical care services, or claims processing as a result of the phase out of the indemnity plan offered to State Health Plan members.

Study Findings and Preliminary Recommendations

Preface: ***Transition costs are unavoidable and anticipated to be substantial. These costs are currently not available to the degree necessary to include them in this report or inform a final recommendation from the Joint Work Group at this time. A second, more detailed report will be provided prior to the initiation of the 2008 State Legislative Session.***

Study Findings and Analysis

- Detailed findings are listed in the study findings section of this document. Key findings related to the two recent studies are:
    - An independent study completed by MAXIMUS did not verify the findings of a performance audit issued by the Office of the State Auditor that EDS claims costs were 12 times lower than BCBSNC claims costs. The MAXIMUS assessment suggests claims processing costs are reflective of a two (2) times cost differential. ($1.76 for BCBSNC claims and $0.88 for EDS claims) This is in contrast to the administrative claims processing costs of $0.41 per claim for EDS versus $4.88 per claim for BCBSNC as reported by the Office of the State Auditor.
    - The number of claims processed under the EDS contract is about 29 times the number of claims processed under the BCBSNC agreement, 51,844,698 and 1,795,512,

respectively. As a result, economies of scale is a significant factor in explaining the difference in cost per claim between the Health Choice and Medicaid programs.

- A separate contract is required for NC Health Choice claims administration under Title XXI; it cannot be incorporated into the EDS contract for the administration of Medicaid under Title XIX.
- In summary, it would be an unsubstantiated conclusion to assume the estimates from either study of Medicaid cost per claim would be transferrable to the NC Health Choice cost per claim if the program were transferred.

Preliminary Recommendations

- Department of Health and Human Services, Division of Medical Assistance should assume full oversight of the NC Health Choice program at a time to be determined.
    - That transition could coincide with the identification of a new vendor. Alternatively, administrative and contract management activities currently performed by the NC State Health Plan could be smoothly transitioned to DMA upon an effective period of knowledge transfer between DMA and the NC State Health Plan. Such a transition plan would require input by both DMA and the NC State Health Plan and be supported by any requisite statutory changes.
    - It is further recommended that the Secretary of the Department of Health and Human Services be provided the authority to make the necessary decisions applicable to the NC Health Choice program that are in the best interest of the children and the taxpayers, including the timeline for the implementation of administrative transition from the North Carolina State Health Plan to DMA.

- BCBSNC should continue to administer NC Health Choice claims processing and transition to their MHS operating system, as needed, effective January 1, 2009. This short-term recommendation is necessary because systems development cannot begin before authorizing legislation is enacted and necessary funding appropriated in the 2008 Regular Session, which convenes in May. Statutory changes are also required to transition administrative and claims processing authority to the Division of Medical Assistance. Systems development, design and implementation activities necessary to

transition to DMA's contractor, will take at least 15 months to complete and may not be the most cost effective plan for maintaining efficient claims processing for NC Health Choice. In addition, BCBSNC has a legal requirement to transition all business from their legacy system by December 31, 2008. Transition costs will be incurred; however, there are no other viable alternatives for the short-term that would ensure program continuity and a smooth transition.

- The Joint Work Group should continue to evaluate whether it is prudent in the long term to transition to the MMIS replacement system or whether to initiate a request for proposal (RFP) process to seek out a new NC Health Choice claims processing vendor. MMIS is the current system utilized to administer the Medicaid program. An RFP is in process for that system replacement. Currently, the plan in place is to begin processing Medicaid, Public Health and Mental Health claims under the new system in late 2010. There may be efficiencies to administering NC Health Choice claims through the MMIS replacement system, but there is also a compelling case for maintaining NC Health Choice in an independent environment. There is not enough information available at this time to make an informed and final recommendation. DMA will continue their assessment process and provide a final recommendation after the issuance of the second and final report from the Joint Work Group.

- Modify the State Children's Health Insurance Program State Plan (federal contract with the Centers for Medicare and Medicaid Services) and NC General Statutes as necessary to maintain the NC Health Choice benefit package as currently offered under the SHP indemnity plan, since timing considerations require administration and claims processing to continue under the SHP and the BCBSNC contract for the short term.

- At a time to be determined, the benefits and coverage design for the NC Health Choice program should be restructured to incorporate coverage policies and administrative procedures similar to those used to administer the Medicaid program to facilitate the transition of NC Health Choice to the Division of Medical Assistance and avoid the need for duplicative program and administrative staff.

- In summary, the key recommendations of the Joint Work Group are as follows:
    - Transition administration of NC Health Choice to the Division of Medical Assistance at a time to be determined.
        - It is further recommended that the Secretary of the Department of Health and Human Services be provided the authority to make the necessary decisions applicable to the NC Health Choice program that are in the best interest of the children and the taxpayers, including the timeline for implementation of administrative transition from the North Carolina State Health Plan to DMA.
    - In the short to intermediate term, maintain BCBSNC as the third party administrator (TPA) responsible for claims administration.
    - The Division of Medical Assistance and the North Carolina State Health Plan will take the necessary steps to maintain the NC Health Choice benefit plan equivalent to those benefits offered in the Indemnity Plan as it is currently structured under the NC Health Choice claims processing contract.
    - The Division of Medical Assistance should continue to weigh the merits of initiating an RFP process to find a new claims processing vendor versus transitioning claims processing to the MMIS system replacement.
    - In order to ensure the most cost effective program on a long term basis, the benefits and coverage design for the NC Health Choice program should be restructured to incorporate coverage policies and administrative procedures similar to those used to administer the Medicaid program.

II. Introduction

The State Children's Health Insurance Program (SCHIP), known as "North Carolina Health Choice for Children," is a state and federally funded program that provides children in families whose incomes exceed the Medicaid eligibility level with access to comprehensive health care coverage with little or no cost sharing required. Enrolled children receive similar coverage as provided to children of state employees and teachers, with the addition of vision, hearing and dental benefits as required by North Carolina General Statute 108A-70.21. Federal funding is obtained under Title XXI of the Social Security Act, and State General Fund appropriations are used to satisfy the federal matching requirements.

The North Carolina SCHIP, in accordance with North Carolina General Statutes, is administered through a partnership of the Department of Health and Human Services, Division of Medical Assistance and the North Carolina State Health Plan. The Division of Medical Assistance makes premium payments to the State Health Plan to cover administration, claims processing and other costs incurred to provide coverage for SCHIP children. The State Health Plan then disburses funds to Blue Cross and Blue Shield of North Carolina (BCBSNC) who is contracted to process and pay SCHIP (hereinafter referred to as NC Health Choice) medical claims.

III. Study Background

During the 2007 Regular Session, the General Assembly enacted legislation to study administration of the NC Health Choice program to ensure a smooth and effective transition in light of the phase out and replacement of the Teachers' and State Employees' Comprehensive Major Medical (CMM) Plan (i.e. the indemnity plan) with a preferred provider organization (PPO) effective July 1, 2008. The legislation was enacted to help ensure NC Health Choice, which is benchmarked to the CMM by state law (i.e. Health Choice coverage is required to be substantially equal to coverage provided to dependents of teachers and state employees), does not experience a disruption in access to care, quality of medical care services, or claims processing as a result of the phase out of the indemnity plan offered to State Health Plan members. The requirements of the study, specified in Section 28.22(j) of S.L. 2007-232, are as follows:

> "To ensure a smooth and effective transition of the administration of the NC Health Choice Program, enacted under Part 8 of Article 2 of Chapter 108A of the General Statutes, and administered under Part 5 of Article 3 of Chapter 135 of the General Statutes, the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan and the Department of Health and Human Services, Division of Medical Assistance, shall meet to discuss the administration of NC Health Choice in view of the implementation of the State Health Plan for Teachers and State Employees effective July 1, 2008. These meetings shall address all issues that may arise regarding the administration of

> NC Health Choice under the State Health Plan, including provider payment rates and collection of applicable premiums and co-payments. The Executive Administrator and the Department shall report to the Committee on Employee Hospital and Medical Benefits not later than February 1, 2008, with recommendations on statutory or other changes necessary to ensure effective administration of NC Health Choice."

It is also noted that a performance audit was issued in July 2007, by the Office of the State Auditor which assessed administrative costs. The State Auditor recommended that the NC State Health Plan propose legislation "to move administrative authority for SCHIP claims processing to the Division of Medical Assistance, or to take other appropriate action, so that the State can take advantage of available administrative costs savings, additional pharmacy rebates, and the use of cash reserves."

A Joint Work Group including representatives from the Department of Health and Human Services, Division of Medical Assistance and North Carolina State Health Plan was formed and began meeting weekly in October 2007. In the belief that the Office of the State Auditor's report did not recognize sufficiently the complexity of claims processing and the plan's administrative costs, an independent study was commissioned by the State Health Plan to further inform the Joint Work Group with respect to administrative costs. MAXIMUS, a consulting firm with expertise in the health care industry, performed the independent study, and it is included in the Appendix.

IV. Alternatives Reviewed

The Joint Work Group focused on the key aspects of the NC Health Choice program and program administration, including agency administration, third party administration, and the plan's benefits and coverage design, which is currently benchmarked to the indemnity plan. Under legislation enacted to phase out the indemnity plan, the PPO plan will replace the indemnity plan as the benchmark for NC Health Choice unless action is taken by the General Assembly in its 2008 Regular Session.

The following primary alternatives were reviewed in relation to the NC Health Choice Program:

Agency Administration

- Maintain "status quo" with joint administration of NC Health Choice by Department of Health and Human Services, Division of Medical Assistance (DMA) and the North Carolina State Health Plan (SHP)
- Transition full administration of the NC Health Choice program to the Division of Medical Assistance

Third Party Administration of NC Health Choice Claims Processing

Although three alternatives were identified with respect to third party administration, it should be noted they are not considered mutually exclusive for the purposes of this study due to timing considerations and other requirements as explained below.

- Maintain BCBSNC as the third party administrator via the current contract with the NC SHP or a new contract with DMA
- Transition administration of claims to EDS, the third party administrator for the Medicaid program operated under Title XIX of the federal Social Security Act
- Procure a new administrator via an RFP process

V. Key Considerations Influencing the Evaluation Process

The Joint Work Group considered and discussed the following key factors and issues in evaluating the alternatives and developing recommendations:

Timing Considerations—Timing considerations lead to the potential need for short term, intermediate and long term planning for administration of NC Health Choice and potentially, increases the cost if multiple administrative changes are made.

The following factors impact timing:

- Legislative Changes: Statutory changes will be required to transition claims administration authority for NC Health Choice to DMA, if approved. In addition, legislation may be required to clarify the use of the state health plan as the NC Health Choice benchmark or to authorize implementation under another federal plan option, including benchmark equivalent coverage, if necessary. Since the 2008 Regular Session does not convene until May 2008, it is presumed that implementation of any significant program changes cannot begin until clarifying legislation is enacted and necessary funding appropriated.
- System and Operational Development: Transition to another technology platform is unavoidable under existing circumstances, because the current administrator is replacing its legacy system with the BCBSNC commercial platform. Since systems development cannot begin before authorizing legislation is enacted to transition the program, the plan can not be operationalized on a new or modified claims processing platform by July 2008. Nor is it likely that a new vendor, selected through an RFP process, could implement this program between the time enabling legislation is enacted and December 31, 2008, which is the date by which BCBSNC expects to phase out the use of its legacy system.

NC Health Choice Benefits and Coverage Design Considerations

When the State of North Carolina originally applied to the US Department of Health and Human Services for approval of its SCHIP program in 1998, the State had three potential benefit design approaches under federal law from which to choose (See Appendix for excerpts from the federal legislation):

1. **Benchmark coverage** providing benefits that are substantially equal to coverage provided under: (1) the federal employees health benefit plan, (2) the state's employee health benefit plan, or (3) the health maintenance organization plan (HMO) with the largest insured commercial enrollment in the state;
2. **Benchmark equivalent coverage** establishing benefits that are determined to be "actuarially equivalent" to one of the three benchmark coverage options, or
3. **Secretary-approved coverage** providing benefits that in the opinion of the Secretary of the US Department of Health and Human Services are appropriate for the SCHIP population of targeted low income children.

To implement the SCHIP program as quickly as possible, the State chose to base the plan off of the "Teachers' and State Employees' Comprehensive Major Medical Plan (indemnity plan)". The State of North Carolina utilized the "Secretary-approved coverage" option to provide "benchmark coverage" based on the State employees active health plan, the indemnity plan, as well as additional coverage for vision, hearing and dental services. The State employee health benefit plan offerings will change effective July 1, 2008, the day following the phase-out of the indemnity plan. Although NC Health Choice was not actively considered when the decision to phase out the indemnity plan was made, it is impacted because under the "benchmark plus additional coverage" approach that the State of North Carolina has taken, the "benchmark coverage" must follow the state health benefit plan for *active* employees. The indemnity plan will no longer be offered to active employees or any other eligibles as of July 1, 2008. Therefore, by default, the benchmark will automatically become one of the preferred provider organization (PPO) options offered to state employees effective July 1, 2008 unless new legislation is passed and further action is taken with CMS prior to July 1, 2008.

The Joint Work Group is evaluating how proceeding with the "default" change in the NC Health Choice benchmark coverage from an indemnity plan to a PPO plan would affect the health benefits coverage provided to eligible children under North Carolina's SCHIP State Plan approved by CMS, the federal oversight agency. If the new PPO benchmark includes significant differences in comparison to the current Indemnity Plan benchmark related to covered services or the methods of delivery and utilization control, then a change to the benefit design of the current NC Health Choice plan or the State Plan filed with CMS, or both, may be required to ensure a smooth and effective transition of program administration.

Indemnity plans operate on a fee for service basis with few, if any, restrictions on provider choice. PPOs operate via a network of providers who agree to accept special reimbursement rates when serving covered members, and enrollees are encouraged to seek treatment from "network providers" through differential cost sharing incentives. Changing from an indemnity plan to a PPO represents a significant change in the method of delivery.

It is important to note, that despite benchmarking to the indemnity plan, the current benefit and coverage design structure for NC Health Choice is not identical to the indemnity plan in terms of reimbursement rates or cost sharing. NC Health Choice providers receive payment based on Medicaid rates rather than SHP indemnity plan rates. Cost sharing requirements for NC Health Choice are set out in G.S. 108A-70.21 and are limited to an annual enrollment fee and nominal co-payments for specified services. They also apply primarily to children with family incomes in excess of 150% of the federal poverty level. In contrast, coverage under the indemnity plan is subject to deductibles, coinsurance and co-payments for all members. Otherwise, covered services and utilization control measures, such as prior approval, are substantially similar for NC Health Choice and the SHP indemnity coverage, but there will need to be changes to the existing NC Health Choice plan to potentially incorporate some key PPO benefits and features if the State chooses not to pursue a different approach. Alternatively, the State could attempt to demonstrate "actuarial equivalency" to one of the approved benchmark options (option 2 listed at the beginning of this section). Under this approach, a member of the American Academy of Actuaries would certify according to the definition under federal law that the "value" of coverage to be provided to SCHIP members is at least "actuarially equivalent" to one of the three coverage

options considered "benchmark coverage". An actuarial evaluation is currently underway to determine if the current NC Health Choice benefit package satisfies the requirement for benchmark equivalency when compared to the State Health Plan PPO offerings. This and other options are under consideration by the Work Group.

Note that a State law cannot be enacted to use the 'benchmark coverage' approach to designate the indemnity plan in statute as the NC Health Choice Plan because there will be no employees on it as of July 1, 2008. However, the State can continue to provide services that are identical or substantially equivalent to those currently provided under the NC Health Choice plan by modifying its Secretary-approved coverage under the state plan.

Another approach being evaluated by the Joint Work Group is determining whether minor changes can be made to the existing NC Health Choice plan that by federal definition make that plan close enough to the PPO plan to allow the State to continue to operate under the current SCHIP State Plan with CMS, and alleviate the need to seek approval for a State Plan Amendment with CMS.

The Work Group also discussed the possibility of utilizing a PPO type approach with no benefit differential regardless of whether a Health Choice enrollee utilized an in-network or out-of-network provider. Currently, there is not enough information to determine the feasibility of this alternative. Although this alternative theoretically might be feasible, it would be necessary to adequately estimate the expected costs of such an approach. Thus, the absence of adequate cost estimates, potential complexities of state law given this approach conflicts with the current statutory definition of a PPO, and the fact that there would be no expected incentives to use in-network providers in such a plan, the Work Group felt that an approach utilizing a PPO should not be considered in the immediate future.

Claims Processing and Transition Costs Considerations

To recommend the most cost effective approach to future administration of the NC Health Choice program, the Joint Work Group needs reliable information on claims processing and transition costs. The estimated costs to transition program administration and claims processing from the current platform and contractual arrangement to another

platform or third party administrator and the on-going operating expenses are also integral to this analysis. The Work Group is seeking cost estimates for the following scenarios:

(1) With respect to administration under SHP, transition from the current administrator's legacy system to the new commercial platform.

(2) With respect to administration under DMA, transition from the SHP to the current Medicaid administrator.

Vendor and System Replacement Considerations

- **MMIS System Replacement**

During the late summer of 2008, the Department of Health and Human Services is expected to award a contract for the design, development and implementation of a new multi-payer claims processing and management information system that will replace DMA's Medicaid Management Information System (MMIS) operated by EDS, the current Medicaid fiscal intermediary. The Joint Work Group does not consider the replacement MMIS system to be a viable short term alternative for consideration, because deployment of the core system is not anticipated until late 2010. However, the Work Group considers the replacement MMIS and a mandate that it be compatible with administration of NC Health Choice, important considerations in evaluating the long term alternatives for administration of NC Health Choice.

- **Vendor Selection**

A request for proposal (RFP) was considered such that a successful bidder would administer the NC Health Choice program. Should a decision be made to require the NC Health Choice program ultimately to be administered using the MMIS replacement claims processing platform, an RFP process would result in three separate administrative implementations: 1) January 1, 2009—Blue Cross and Blue Shield of North Carolina (BCBSNC) transitions from its legacy system to its MHS claims processing operation and platform 2) For Effective Dates Yet To Be Determined--- transition from BCBSNC' MHS system to RFP vendor's system and 3) Effective Dates Yet to Be Determined -- Transition to the replacement MMIS.

- **Variance in capabilities of third party administrators**

The Joint Work Group recognizes NC Health Choice providers currently have access to specialized programs that provide convenience and benefits because the Health Choice program is administered by BCBSNC. These specialized programs are not available in the current MMIS legacy system operated by EDS. Due to cost considerations and the planned replacement of the MMIS legacy system, the Joint Work Group does not expect such specialized capabilities to be replicated in the short term should administration of NC Health Choice be transitioned to another third party administrator. Examples of specialized programs and services offered through BCBSNC and/or Medco that may not be available through other third party administrators include:

- **Blue e** – Blue e is a benefit and eligibility program used by institutional providers and large professional provider practices to determine eligibility for coverage and benefits available. EDS and other third party administrators do not use, update or have access to this system.

- **RxHub** –Rx Hub functions as a switch for electronic prescriptions submitted by a physician. Anytime a physician transmits a prescription to Medco or other participating Pharmacy Benefit Manager (PBM), it is routed through RxHub. RxHub consolidated the numerous connectivity options available to physicians and software vendors. Instead of a physician having to submit prescriptions electronically through multiple systems to multiple PBMs, RxHub provides a single point of contact for physicians.

- **Provider payments** – Currently Health Choice providers receive claims payments weekly. Medicaid providers are reimbursed 42 times per year by EDS based on its current contract with DMA. Depending on the provider, this could impact the provider's cash flow significantly.

- **Explanation of Benefits** – Currently Health Choice recipients receive an explanation of benefits (EOB) summarizing services received and charges paid by the plan. Medicaid recipients do not receive similar reports. The loss of this communication is likely to confuse Health Choice members and will reduce program transparency.

It is difficult to quantify the impact that such losses in functionality might create; however it is reasonable to conclude that there will be a negative qualitative impact on

providers that will also affect NC Health Choice recipients. Removing operational efficiencies that have supported the NC Health Choice program for years, particularly in view of the declines in reimbursement rates since 2006 when Medicaid rates were enacted, may result in significant shifts in access to care. Furthermore such changes would result in longer wait times and less efficient processing of prescriptions and referrals for consumers, ultimately contributing to poorer compliance with treatment plans and less optimal health outcomes.

VI. Study Findings and Analysis

Study Findings

Cost Analysis:

The State Auditor's report of July 2007 recommended a transition of NC Health Choice administration to DMA. This recommendation was based on the State Auditor's conclusion that a Medicaid claim is adjudicated at an administrative cost of $0.41 per claim compared with a cost of $4.88 per claim to adjudicate a NC Health Choice claim. The *comparative* numbers from the MAXIMUS Study are $0.88 per Medicaid claim and $1.76 per BCBSNC claim. It is important to note the following:

- The Independent Study did not validate the State Auditor's conclusion that EDS claims costs were 12 times lower than BCBSNC claims costs. The MAXIMUS assessment suggests claims processing costs are reflective of a two (2) X cost differential.
- The $1.76 amount for medical claims for BCBSNC removes all costs, not directly associated with claims processing. For example booklet and ID card production, full IT support for development and maintenance of services, and provider relations support as needed are excluded from the BCBSNC costs in an attempt to achieve a valid comparison with Medicaid experience.
- The independent study found that total NCHC medical claim cost is $4.73 per claim, including $4.42 per claim paid to BCBSNC, $0.12 per claim for NC State Health Plan services and an imputed $0.19 per claim for DMA to support the Health Choice claims adjudication process. The $4.73 per claim includes costs such as IT support for development and maintenance of services and booklet and ID card production. The comparable Medicaid total claims cost approximates $0.96 per claim to adjudicate a Medicaid claim, including DMA support. To summarize:
  - $4.42 (All BCBSNC services) + $0.12 (SHP NC Support) + $0.19 (DMA Support) = $4.73 for Medical NCHC claims

- $1.72 (Medco Claim Services for RX) + $0.04 (SHP NC Support) =$1.76 for RX NCHC claims. It is coincidental that this is identical to the $1.76 mentioned above, the direct administrative cost to adjudicate a Health Choice claim.
- $0.88 (EDS Services) + $0.08 (DMA Support)=$0.96 for Medicaid Claims

- The number of claims processed under the EDS contract is about 29 times the number of claims processed under the BCBSNC agreement, 51,844,698 and 1,795,512, respectively. As a result, economies of scale is a significant factor in explaining the difference in cost per claim between the Health Choice and Medicaid programs
- The State Auditor's estimate of savings that could be realized if the Health Choice program is transitioned to DMA apparently assumes that the NC Health Choice program would be identical to the Medicaid program, rather than maintaining its current coverage and benefits policies. This is unlikely and as a result, Health Choice costs per claim would be higher than Medicaid costs per claim if the NC Health Choice program were to be transitioned to EDS as the administrator. For example, a Medical Director may be required to support NC Health Choice exclusively, and a cost per claim differential can be expected to continue so long as NC Health Choice benefits, authorization processes, and data management differ from the NC Medicaid program. Although some benefit from economies of scale should be expected, it is not possible to quantify with certainty an expected cost per claim were the NC Health Choice program to be transitioned to the EDS platform.
- In addition, the assumption that the NC Health Choice program would be identical to the Medicaid program affects the estimate of systems development costs which transition would require. Preliminary conversations with EDS indicate that systems development costs would be significantly greater than the estimate in the State Auditor's Report if NC Health Choice maintains its own coverage and benefits policies.

- A separate contract is required for NC Health Choice claims administration under Title XXI; it cannot be incorporated into the EDS contract for the administration of Medicaid under Title XIX.
- In summary, it would be an unsubstantiated conclusion to assume the estimates from either study of Medicaid cost per claim would be transferrable to the NC Health Choice cost per claim if the program were transferred.

Situational Analysis

Third Party Administrator:

When the NC Health Choice program was created, the NC General Assembly elected to establish coverage under the federal plan option allowing states to benchmark SCHIP coverage to the state's employee health benefit plan and assigned responsibility for administration and claims processing to the State Health Plan. This arrangement not only allowed for timely implementation, but eliminated the need for DMA to establish an identical claims processing system, and alleviated concerns about quality and access to care. It also firmly established the SCHIP program as a separate, non-entitlement program.

Many of the initial advantages no longer apply. Over time the program requirements for NC Health Choice have begun to differ from the benchmark indemnity plan and a few operational challenges have become apparent. For example, unlike teachers and state employees whose coverage is usually applicable for the entire plan year, a child's eligibility for NC Health Choice is based on income and other factors, necessitating periods of eligibility that may be less than twelve months. However, enrollee identification (ID) cards cannot currently be issued for a shorter period of time. Since providers cannot rely on the ID cards, they must either verify eligibility independently or risk providing services to ineligible children. In addition, in 2006 legislation was enacted to reimburse providers under NC Health Choice at the Medicaid rate and enroll children in the primary care case management program established through the Medicaid program. These changes require modifications to the claims processing system that are applicable only to NC Health Choice enrollees.

The performance audit and independent study indicate that savings can be realized by transitioning administration of NC Health Choice from the NC SHP to DMA. Phase-out of the

indemnity plan and its replacement with a PPO for teachers and state employees are the latest developments that suggest reconsideration of the current administrative structure is warranted.

Given the apparent differences in claims processing costs, albeit not as significant as previously reported, and the continued divergence of similarities with the health care coverage provided for teachers and state employees, the Joint Work Group finds that transitioning administration of NC Health Choice to the Division of Medical Assistance will better serve both enrolled children and North Carolina Taxpayers.

Benefits and Coverage Design Analysis:

The benchmark coverage for NC Health Choice will change effective July 1, 2008 to the active PPO plan for State employees, unless other action is taken. The Joint Work Group examined all of the following possibilities for NC Health Choice plan design going forward after July 1, 2008:

- Maintaining the current (pre-July 1, 2008) Indemnity Plan Design
    - This approach would require a filing with CMS. For example, a filing based on "Benchmark equivalent coverage" to demonstrate that the current NC Health Choice Plan is equivalent in value to the PPO, could be undertaken. If approved, this approval would allow us to continue to offer the existing plan with no changes.
- Offering a PPO program to NC Health Choice members to align with the new benchmark coverage effective July 1, 2008.
    - This potential option is assessed in this section.
- Making some changes in covered services and programs to the Indemnity Plan to match the covered services and programs available to State employees in the PPO plan.
    - This potential option is assessed in this section.
- Redesigning the NC Health Choice program to more closely align to Medicaid delivery systems, benefits, policies and procedures.
    - This approach would require a filing with CMS under a different coverage option allowed by Federal Law This is discussed below, and is viewed more as a long term option.

Because the benchmark coverage for NC Health Choice is undergoing significant changes in the underlying method of delivery and utilization control, North Carolina will have to amend its federal SCHIP State Plan to ensure it continues to accurately reflect coverage provided to NC Health Choice children. However, this does not mean the State necessarily has to adopt the service delivery method, covered benefits, and utilization controls of the new benchmark (i.e. the SHP PPO), but it may require federal approval under a different SCHIP program coverage option.

The state can choose to operate the SCHIP program under any of the following types of health benefits coverage reiterated below:

- **Benchmark coverage** providing benefits that are substantially equal to coverage provided under: (1) the federal employees health benefit plan, (2) the state's employee health benefit plan, or (3) the health maintenance organization plan (HMO) with the largest insured commercial enrollment in the state;
- **Benchmark equivalent coverage** establishing benefits that are determined to be "actuarially equivalent" to one of the three benchmark coverage options, or
- **Secretary-approved coverage** providing benefits that in the opinion of the Secretary of the US Department of Health and Human Services are appropriate for the SCHIP population of targeted low income children.

Given the inherent differences in the benefit delivery systems of indemnity plans and PPOs, it is unclear whether NC Health Choice can continue to satisfy the federal requirements of benchmark coverage, as currently tied to the state's employee health benefit plan which is a PPO, without modifying the current plan or offering a PPO-like plan. Attempting to serve NC Health Choice children through the PPO networks is in contrast to and will undermine recent efforts to enroll them in Community Care of North Carolina (CCNC), a community based care coordination and disease management model that provides each child with a medical home and incorporates evidence based practices and quality improvement initiatives. Likewise, the 2006 legislative mandate to reimburse NC Health Choice providers at the Medicaid rate conflicts with one of the underlying tenets of PPOs: negotiated rates for network providers.

Even assuming that CMS will allow NC Health Choice to continue its Secretary-approved benefit plan as tied to the PPO as of July 1, 2008 without a change to provider

networks, reimbursement policies, and cost sharing differentials, in order to establish compliance with the new PPO benchmark coverage, the State likely will have to conform to any changes in covered benefits and utilization control. NCSHP has continued to direct BCBSNC to process claims according to the currently effective NC Health Choice plan. At this time, there are no plans for BCBSNC to modify their legacy system to conform to any benefit or utilization control differences, and there has been no specific direction to do so, However, it will be difficult to modify the BCBSNC legacy claims processing system based on the PPO coverage policies because the BCBSNC legacy system will be phased out as of December 31, 2008. As such, the Joint Work Group believes it best to modify the State Plan (filed with CMS) and NC General Statutes as necessary to maintain the NC Health Choice benefit package as currently offered under the SHP indemnity plan, since timing considerations require administration and claims processing to continue under the NCSHP and the BCBSNC contract for the short term.

Federal approval of a State Plan Amendment that would change our benchmarking approach is not anticipated to be a major obstacle as discussions have ensued with CMS, and NC can likely continue the current benefit package by satisfying the requirements for Secretary approved coverage or benchmark equivalent coverage. An actuarial evaluation is also currently underway to determine if the current NC Health Choice benefit coverage satisfies the requirement for benchmark equivalency when compared to the SHP PPO offerings as previously discussed in this document.

Although maintaining the NC Health Choice benefit package as currently offered under the SHP indemnity plan makes the most sense in the short term, the Joint Work Group concludes that the benefits and coverage design ultimately should be restructured to incorporate coverage policies and administrative procedures similar to those used to administer the Medicaid program to facilitate the intermediate or long term transition of administration to the Division of Medical Assistance and avoid the need for duplicative program and administrative staff.

VII. Preliminary Recommendations

Preface: ***Transition costs are anticipated to be substantial. These costs are currently not available to the degree necessary to include them in this report or inform a final recommendation from the Joint Agency Work Group at this time.***

- Based on all factors affecting NC Health Choice and the steps required to ensure a smooth transition, recommendations will reported in two phases: On February 1, 2008, recommendations are reported on a high level. The Joint Work Group will report more detailed recommendations, including proposed time lines, prior to the start of the 2008 Legislative Session.

- Short-term and long-term recommendations are included in this report. Short-term recommendations are necessary due to business and implementation constraints on the part of both BCBSNC and EDS.

Agency Administration

- Administrative and contract management activities currently performed by NC State Health Plan should be transitioned to Department of Health and Human Services, Division of Medical Assistance (DMA) at a point in time to be determined. That transition could coincide with the identification of a new vendor. Alternatively, administrative and contract management activities currently performed by NC State Health Plan could be transitioned smoothly to DMA upon an effective period of knowledge transfer between DMA and the NC State Health Plan. Such a transition plan will require input by both DMA and the NC State Health Plan staff and be supported by requisite statutory changes.
    - NC State Health Plan staff for administration of the NC State Health Plan and NC Health Choice is integrated, so there is no opportunity to transfer staff allocations from the NC State Health Plan to Division of Medical Assistance. Additional analysis is required to determine the degree to which DMA can

integrate activities into the duties of existing staff and it is presumed that additional staff will need to be added by DMA.

Third Party Administration

- The NC Health Choice plan should remain with BCBSNC and be transitioned to their PowerMHS system. Based on BCBSNC's transition schedule and legal requirements to phase out their legacy system, all plans, including NC Health Choice, must be transitioned from their legacy system on or before December 31, 2008. EDS has indicated that it will require 15 months of systems development effort to transition the NC Health Choice program to the legacy MMIS platform. EDS would not initiate systems development efforts until authorizing legislation were passed by the General Assembly. As a result, EDS is not a viable option in the short term. An alternative might be to seek another vendor via an RFP process. However, it is unlikely that an RFP process could be initiated, an award made and a new system in place by January 1, 2009 without some disruption and adverse impact to membership. It should be noted that this is a preliminary recommendation because costs to transition the Health Choice program to the MHS platform are not yet available from BCBSNC.

- Timing considerations require claims processing for the Health Choice program to be moved to the MHS platform on or before January 1, 2009. Nevertheless the Joint Work Group should continue to evaluate the advisability and potential of placing the Health Choice program on the current MMIS legacy platform administered through EDS versus pursuing a new vendor through an RFP process.

- Due to the timing of the MMIS replacement process, the Joint Work Group does not yet have enough information to recommend that the Health Choice program ultimately transition to the replacement MMIS. Such a recommendation could be made only when more information regarding the capabilities of the replacement MMIS become available. (A key long term influence regarding transition of the NC Health Choice program is the potential for the MMIS replacement system to

eventually incorporate claims administration of the NC Health Choice program. The new MMIS system is expected to be operational by late 2010. Although the new MMIS is required to incorporate only the ability for the NC Health Choice system to "talk to" the MMIS Replacement System, there has also been discussion about full assumption of claims administration activities after phase-in of Medicaid, Division of Public Health and Division of Mental Health claims.)

- The Joint Work Group will need to weigh the costs and timing of three potential system implementations if an RFP process to select a new vendor is recommended without a definitive decision regarding the MMIS replacement system.

- Regardless, Health Choice claims administration will need to transition to BCBSNC's MHS system given the BCBSNC requirement to be off of the BCBSNC Legacy system by December 31, 2008.

Plan Benefits and Coverage Design

- Modify the SCHIP State Plan (filed with CMS) and NC General Statutes as necessary to maintain the NC Health Choice benefit package as currently offered under the SHP indemnity plan, since timing considerations require administration and claims processing to continue under the SHP and the BCBSNC contract for the short term.
- In the intermediate to long term, restructure the benefits and coverage design to incorporate coverage policies and administrative procedures similar to those used to administer the Medicaid program to facilitate the transition of NC Health Choice to the Division of Medical Assistance and avoid the need for duplicative program and administrative staff.

VIII. Glossary

1. **Blue Cross and Blue Shield of North Carolina (BCBSNC)—**for the purposes of this report, the organization that contracts with the North Carolina State Health Plan to administer claims processing for the SCHIP.

2. **Benchmark—**Benchmark for the purposes of this document is a method used by the Federal Government and written into Federal Law to ensure that SCHIP programs are substantially equivalent to plans are that are available to key governmental groups and compliant with SCHIP requirements. (See Exhibit 3 in the Appendix)

   (Note that for purposes of the Federal Benchmarking requirements, benchmarks are evaluated based on covered services and the delivery systems and programs around those covered services—matching the benefit provisions of the plan, such as in and out of network structure, deductibles, coinsurance and copayments, are not necessarily required)

3. **Centers for Medicare and Medicaid Services (CMS)—**CMS is the federal oversight agency that approves and oversees the SCHIP program at the federal level. States must submit plans compliant with Federal statute to CMS for approval. This body is also referred to as "CMS" in the document.

4. **Comprehensive Major Medical (CMM) Plan—**A type of health benefit plan that covers a wide breadth of services and incorporates member cost-sharing via up-front deductibles, coinsurance and copayments for most services. These types of plans typically reimburse providers based at a pre-determined level, and there is not a provider network associated with this type of program. For the purposes of this document, the Comprehensive Major Medical Plan, also referred to as the CMM or Indemnity Plan, is the Plan offered to North Carolina State Employees and Retirees that will be phased out effective July 1, 2008.

5. **Division of Medical Assistance (DMA)**—the Agency responsible for the management of Medicaid and the budgetary and administrative management of the SCHIP program with the exception of claims administration. (By Statute, the NC State Health Plan contracts with the third party administer for State employee claims to provide claims processing services for the SCHIP program.)

6. **Electronic Data Services (EDS)—**EDS is the Third Party Administrator that is responsible for claims processing on behalf of the Division of Medical Assistance for Medicaid.

7. **Joint Work Group—**the work group established to evaluate the current administration of NC Health Choice due to the phase out of the Indemnity Plan, that is the current Benchmark for the NC Health Choice program.

8. **Legacy System**—the current claims payment system utilized by BCBSNC to process NC Health Choice and Indemnity Plan claims. For Legal and operational reasons, BCBSNC needs to phase out the Legacy system by December 31, 2008.

9. **Medicaid Management Information System (MMIS)**—MMIS is the system currently used by DMA and EDS their third party administer to administer and pay claims for the Medicaid Program. This term is also referred to as MMIS in the document without utilizing the entire name of the system.

10. **MHS Processing System**—the current system utilized by BCBSNC to process most commercial claims as well as North Carolina State Health Plan PPO claims.

11. **MMIS System Replacement**—an RFP is in process for the planned replacement of the MMIS system (described above). This system is planned to administer Medicaid, Public Health and Mental Health claims.

12. **NC Health Choice**—the name of the North Carolina SCHIP program to differentiate the plan from Medicaid. In the report, this program is referred to interchangeably as 'SCHIP", "NC Health Choice" or "Health Choice".

13. **North Carolina State Health Plan (also referred to as State Health Plan)**—the state entity responsible for all state employee health plans, and management of the relationship with the third party administrator for the claims administration of the NC Health Choice plan. (Note that at one time this entity was referred to as "the Comprehensive Major Medical Plan", but it was no longer an appropriate moniker as plan offering for State employees diversified.

14. **PPO or Preferred Provider Organization Plan**—A type of health benefit plan in which contracts are negotiated with participating providers to accept their contract amount as payment in full and by contract agree to comply with plan policies and procedures such as prior approval for certain services. By state law, network providers must be credentialed, and the network must provide access to all types of covered services. These types of plans cover both in-network and out-of-network or non-contracted providers. The design must incorporate different benefit levels and member cost-sharing for in-network versus out-of-network services, thus providing incentive for members to utilize in-network providers.

    The North Carolina State Health Plan currently offers three PPO options and one Indemnity or CMM plan option. As of July 1, 2008, the CMM plan will be phased out. As NC Health Choice is currently based on whatever active plan is in place for employees, PPO will become the benchmark for NC Health Choice effective July 1, 2008 unless a new application or amendment is made to CMS to change that and state legislation is changed to designate another type of coverage as NC Health Choice coverage.

(Note that for purposes of the Federal Benchmarking requirements, benchmarks are evaluated based on covered services and the delivery systems and programs around those covered services—matching the benefit provisions of the plan, such as in and out of network structure, deductibles, coinsurance and copayments, are not only not required, but run counter to the needs of limited cost-sharing for this population.)

15. **Request for Proposal (RFP) process**—a formal contracting process that outlines requirements in a document referred to as a request for proposal, RFP, and offers the opportunity for vendors to bid on a contract based on agreed to specifications and a formal and confidential bidding process.

16. **SCHIP**—the State Children's Insurance Program that is a state and federally funded program that provides children in families whose incomes exceed the Medicaid eligibility level with access to comprehensive health care coverage with little or no cost sharing required.

17. **SCHIP State Plan or SCHIP State Plan Amendment or State Amendment**—these are the plans or amendments filed with the Centers for Medicare and Medicaid Services (CMS) on behalf of SCHIP programs to seek changes to the SCHIP benefit design, and there are three approaches allowed by federal law to create an approved benefit design, including: 1) benchmark coverage 2) benchmark equivalent coverage 3) Secretary-approved coverage (as defined on pages 12 and 22 in the document.)

18. **Teachers and State Employees' Comprehensive Major Medical Plan, also known as the Indemnity or CMM plan—**For the purposes of this document, the Comprehensive Major Medical Plan, also referred to as the CMM or Indemnity Plan is the Plan offered to North Carolina State Employees and Retirees that will be phased out effective July 1, 2008. This is also the plan that is currently the basis for NC Health Choice benchmark, although the NC Health Choice and CMM plans are different. By state statute, the SCHIP plan offers coverage for a small copay or no copay at all depending upon income level of the family.

19. **Third Party Administrator**—For the purposes of this document, a Third Party Administrator is a company that administers claims on behalf of an employer group, agency or entity. The TPA for SCHIP claims is BCBSNC. The TPA for Medicaid is EDS.

IX. APPENDIX

MAXIMUS Claims Processing Analysis

February 2008

CLAIMS PROCESSING ANALYSIS

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

JANUARY 2008

PREPARED BY MAXIMUS

FOR THE NORTH CAROLINA STATE HEALTH PLAN

INTRODUCTION

BACKGROUND

The North Carolina State Health Plan (SHP) provides health care coverage to more than 642,000 teachers, state employees and retirees. In addition, the SHP administers North Carolina Health Choice for Children (NCHC), which provides health insurance to uninsured children in North Carolina. NCHS is a fee-for-service program affording free or low-cost health insurance for children and teens up to their nineteenth birthday. Currently more than 116,000 children are covered under NCHC. Most children are able to obtain all necessary services under NCHC plan. However, children in need of services not covered by this core plan may qualify for additional coverage. This coverage is called the Special Needs Services Plan. Both NCHC and the Special Needs Plan are often referred to as the State of North Carolina's Children's Health Insurance Program or SCHIP. SCHIP is a State and federally funded program established under Title XXI of the Social Security Act.

The North Carolina SCHIP is administered through a partnership of the Department of Health and Human Services, Division of Medical Assistance (DMA) and the SHP. Currently, the state contracts with three outside medical claims processors. The SHP contracts with Blue Cross and Blue Shield of North Carolina (BCBSNC) and Medco Health Solutions to process claims for the Teachers' and State Employees' Comprehensive Major Medical Plan (CMM), NCHC claims and Special Needs Services claims. The DMA contracts with Electronic Data Systems (EDS) to process Medicaid claims. Each contractor charges different rates to process medical claims.

This report provides an in-depth analysis of the claims processing functions of each of the three contractors. Additionally, this report addresses the quantification of all administrative costs incurred in support of each of the contractors by the SHP and the DMA. The project objective, methodology and scope of services are discussed in our detailed report to follow.

OBJECTIVE

The overall objective of the study is to provide the SHP with an analysis that identifies the total actual Fiscal Year Ended June 30, 2007 claims processing costs for each contractor (BCBSNC and Medco and EDS). Additionally, the study addresses the actual Fiscal 2007 administrative or support costs incurred by both the DMA and SHP as it pertains to each of the "claims processing" contracts. The study is intended to provide a comprehensive comparison of all claim processing functions. We acknowledge that this has been challenging simply due to the fact that there are very few similarities in how each of the contractors process the varied types of claims contracted to each.

The main goal of the study is to present an average cost per claim processed by each of the contractors based on actual expenditures for Fiscal 2007. This information is intended to be used, in combination with other factors, to determine whether the State of North Carolina is currently utilizing the most cost effective approach to process NC Health Choice claims. We are comfortable in the validations made that the claims processing costs provided are as follows:

- BCBSNC – costs attributable to BCBSNC as initially provided totaled $7,929,536.01 during FYE June 30 2007. When reconciling these costs to SHP journal entries reflecting payments by the SHP to BCBSNC, SHP records indicate that a total of $9,597,150.67. The variance between the two amounts was verified with SHP as simply an accounting period payment issue for an invoice paid during the review year but applicable to prior year work performed. Based on the additional analysis conducted and validated by the project team the actual validated costs attributable to claims processing services during the fiscal year analyzed totaled $7,929,536.01.
- EDS – costs attributable to EDS claims processing operations totaling $45,494,059.00 have not been validated in total at this time. The costs that are not validated represent the EDS "base" contract costs totaling $34,954,130.00. These base contract costs were not provided in the detail needed to compare related functions applicable to claims processing operations. Although EDS did not validate the costs on a per employee basis we feel the amounts reported as compared to the staff assigned and our detailed interviews that the costs incurred by DMS could be supported and documented by EDS and were comparable to the amendment related costs that MAXIMUS was able to validate totaling $10,539,929.00.

Our analysis has encompassed complete reviews (interviews) of personnel directly or indirectly involved with claims processing responsibilities. To date MAXIMUS has interviewed all applicable staff at EDS, BCBSNC, the DMA and SHP. We have also obtained and reviewed the actual fiscal 2007 costs of each of the aforementioned entities. Further, 100% of the claims processed by the EDS and BCBSNC contractors have been obtained, sampled, and tested for accuracy.
The sections that immediately follow will provide interested parties with an all encompassing analysis of our work performed, data reviewed, and actual costs of services incurred during Fiscal 2007. Each of the entities analyses are contained in separate sub-sections below.

COST ANALYSIS

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

The State of North Carolina has contracted with BCBSNC to administer its traditional health plan for state employees, teachers and retirees through a plan called the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical "CMM" or as more commonly referred to, the State Health Plan, and NC Health Choice. The State Health Plan and NC Health Choice have unique intervention programs, mental health care management, and Member Health Partnerships programs. For purposes of this report the information contained herein applies specifically to the State Health Plan and its claims processing contractors BCBSNC and Medco in administering NC Health Choice and Special Needs Services or SCHIP programs under Title XXI and Medicaid guidelines. A detailed overview of BCBSNC claims processing operations and related costs is provided below.

BCBSNC Claims Processing:

The MAXIMUS review team met initially with BCBSNC administrators responsible for administering the contractual obligations of the SHP agreement for claims processing. Our team interviewed each of the BCBSNC Units engaged in the NC Health Choice and Special Needs Services claiming arena. More importantly the BCBSNC Claims Audit Section provided detailed reports and internal control procedures which were utilized by the project team in understanding and reviewing the claims processing functional operations and are provided in this section of our analysis.

The BCBSNC claims area consists of two separate and distinct responsibility centers (divisions) applicable to SCHIP claims processing. The front end claims processing division referred to as the State Claims Unit consisted of 39.93 FTE's during the period under review. The back end claims review or Suspension Area employed 45.67 FTE's during Fiscal 2007. These two divisions of the State Claims Unit provide both the front and back end reviews and processes for all State claims. The Unit itself is responsible for the adjudication of claims. Claims are received from members and health care providers (including clearinghouses, billing services and other healthcare partners). Member submitted claims are received on paper via the USPS mail. Approximately 84% of the provider submitted claims are received electronically via batch submission or interactively over the Internet through BCBSNC sites known as "*Blue e or RealMed*".

BCBSNC has adopted clear and concise internal control procedures with pre-designated objectives required to complete each step in the claiming process. For purposes of this analysis, MAXIMUS feels it important to elaborate on the paper versus electronic claim processing steps and our report will contain a detailed description of the processes for each of the contractors within their respective sections of this report.

BCBSNC paper claims are forwarded to the BCBSNC Image Distribution Center (IDC) and are tracked on a spreadsheet that depicts the receipt date, sender and total documents received. Any attachments are reviewed in advance during the front end review to ensure the necessary subscriber information is correct and that all attachments are applicable to that subscriber. The

IDC sorts the claims and batches them by type and assigns them a unique control number based on the date of receipt. This date will be used to track the claim throughout the system.
Paper claims are scanned into the FormWare system that marks each claim with a unique image address that can easily be tracked by the Front End Processors. Form Ware uses the programmed edit checks to identify required fields with incorrect or missing data. There are currently ten required fields. If the data is incomplete or appears inaccurate, the claim is mailed back to the sender requesting the completion of the missing or inaccurate data.

Access to the claims processing functions and related data files are restricted and HIPAA compliant. The front end processors compare each claim scanned by the IDC to the claim information processed by FormWare and makes any necessary adjustments. FormWare is configured to automatically correct some of the errors. Those that cannot be corrected are mailed back to the provider for the appropriate corrective actions. After this initial front end review is completed Operations staff uploads the claims data to the Mainframe.
Electronic claims are received on-line from terminals at various provider locations and are fed to the automated claims adjudication system via the provider's communication system. Providers are responsible for correcting any errors detected from the initial system edits check of the claim submitted. Control balancing procedures are conducted to ensure that all received claims were received and worked by the automated claims adjudication system.

Claims are adjudicated once properly entered into the system via an automated process which includes programs for transactions validation, membership eligibility verification, liability determination, provider reimbursement, activity recording, and reporting. Subsequently, batch processing will result in either claims being paid, rejected or suspended. Claims can be suspended for varied reasons. For example, if a claim fails any of the aforementioned edits validations, they will be suspended until corrected or further reviewed and determined accurate. BCBSNC staff generates daily suspense reports that are continually reviewed and contain aging data as well as a detailed explanation of the cause to be suspended. Further, these reports facilitate correction or reprocessing as soon as possible. Resubmitted claims are subjected to the same edits and validations as the originally submitted transactions. Specific and designated staff is responsible for the handling of *high-dollar* claims requiring an additional approval prior to payment. BCBSNC management reviews daily and monthly reports which detail the number of claims reviewed, the number and types of error rates. A final review results in an additional control objective applicable to the BCBSNC internal control guidance.

Claims that have been successfully programmed contain edits and validations processes in the automated claims adjudication system are then automatically transferred to the Claims Payment system.

BCBSNC Benefit Entitlement:

Benefits for all claims are calculated by the system using programmed payment rules maintained in the benefit files. Claims exceeding a set threshold are reviewed for validity by the claims supervisor. Each step requires a BCBSNC Internal Control objective to be met. The payment phase requires staff to sort checks to ensure that BCBSNC has to cut only one check per payee, produce the checks, generate notifications of payment, claims activity summaries, and generate

claims disbursement reports. Automated user controls are employed to verify completeness of file transfers from one system or program to another. BCBSNC uses an automated balancing package which compares both the total number of records and total dollar value transferred. BCBSNC general ledgers are balanced and synchronized to the proper accounting period with the claims adjudication and claims payment systems. Out-of-balance conditions are detailed in an error report which is reviewed and resolved by finance and the appropriate assigned staff. BCBSNC holds all claim checks until an out-of-balance issue is fully resolved. Post payment claims audits are performed each day by the Internal Audit Department.

BCBSNC Claims Payment and Reporting:

Each day BCBSNC Quality Assurance Analysts review pre-disbursement claims exceeding set dollar thresholds to ensure accurate payments. During Fiscal 2007 all quality assurance and customer service and provider educators consisted of 78.83 FTE's while an additional 8.19 FTE's supported all claim appeals. Additional pre-disbursement reviews are conducted and cash disbursements personnel track checks on a daily basis. Checks are either mailed directly to the group employee or provider or are taken directly to the bank in the case of direct deposit arrangements. Additionally, claims processing operations were supported by 17.70 FTE's in the Special Projects Unit while an additional 31.04 FTE's make up the Medical Review Unit.

BCBSNC COST OF SERVICES SUMMARY

BCBSNC maintains financial data and cost allocation details applicable to their contract with SHP. The MAXIMUS project team initially obtained all summary detail of the costs and allocations associated with this claims processing initiatives. Our employee interviews with knowledgeable staff throughout each divisional responsibility center provided an all encompassing analysis of the project as contained in the SHP contractual provisions. All staff related payroll and benefits costs were analyzed and verified back to actual payroll and expenditure detail reports without exception. The total costs incurred for Fiscal 2007 in support of the claims processing contract were $7,929,536.01. This amount is broken down by BCBSNC functional responsibility center as follows:

- Account 381 – State Claims ……$328,781.86
- Account 382 – State Project Implementation …… $ 7,410.14
- Account 383 – State Review …… $1,144,530.89
- Account 384 – State Customer Service …… $1,215,681.91
- Account 385 – State Administrative Services …….. $ 79,944.63
- Account 388 – State Membership Services …….. $ 141,545.06
- Account 389 – State ASO …… $ (245,014.35)
- Account 390 – State Medical Review ……... $ 414,551.26
- Account 391 – Other State Project Expense …….. $ 65,026.29

Sub – Total Claims Processing Costs …… $3,152,457.69
Cost per Claim (Claims Processing Costs Only) ……. $ **1.76**

- Various Accounts – IT/Network Personnel Costs ……. $ 944,059.00
- BCBSNC Corporate Costs ……. $3,833,019.32 *

Total FY 2007 BCBSNC Claims Processing Costs ……..$7,929,536.01
Total FY 2007 SCHIP Claims Processed …….. 1,795,512
FY 2007 BCBSNC Cost per Claim ……. $ **4.42**

* BCBSNC Corporate Costs totaling $3,833, 019.32 consist of various administrative, overhead and other corporate level expenditures as determined through a detailed allocation of these costs over numerous statistical basses most applicable to that specific cost component to be allocated. For example, BCBSNC costs incurred for their companywide purchasing operations benefits each of its departments, divisions and offices. The full costs of purchasing operations would then be distributed to all BCBSNC user agencies based on the number of purchase orders processed for each. Other costs that make up the corporate cost amount determined above are but not limited to; the Chief Financial Officer's operations, legal, accounting and reporting, budgeting, human relations, facility costs, mail services, and training to name a few. All allocations of these costs are supported by detailed spreadsheets and allocation bases most commonly used in both private and governmental entities to distribute administrative or indirect service costs.

MEDCO HEALTH SOLUTIONS

The SHP separately contracts with Medco Health Solutions (Medco) for processing NCHC pharmacy claims. During FY 2007, Medco processed a total of 693,980 NCHC related claims totaling $51,181,683.09 in payments. Administrative fees or actual costs paid to Medco for these services totaled $1,191,717.81 for the same period. Medco data also identified a total of $3,483,463.68 in pharmacy rebates and were reflected in four invoices during Fiscal 2007. Due to the nature of the contract between Medco and the SHP our analysis was limited to summary schedules of claims, pharmacy payments and rebates and the administrative costs incurred for Medco services. Based on the limited information provided MAXIMUS still feels that consolidating NCHC claims within the DMA Medicaid population claims would certainly offer greater rebates. We are not certain if these rebates would be as great as originally studied based on the limited review conducted. MAXIMUS conducted no further reviews or validations of Medco operations. The total costs per pharmacy claim during Fiscal 2007 is $1.72 per claim processed.

ELECTRONIC DATA SYSTEMS

The Division of Medical Assistance contracts with Electronic Data Systems (EDS) to process their Medicaid claims. During Fiscal 2007, EDS assisted the DMA with the processing of all medical, pharmacy, and medical supply claims. The MAXIMUS project team conducted interviews with the EDS managers or supervisors of each department that plays a role in processing Medicaid claims. Based on the provided EDS Corporate structure applicable to the Medicaid claims processing agreement with DMA the project team was able to determine the appropriate departments and relevant staff members to interview with no difficulties.
Our initial meeting with EDS provided for the immediate review of claims data and the organizational structure of the EDS claims processing agreement with the DMA. Each of the department representatives interviewed stated that 100% of their work was dedicated to Medicaid claims processing thereby permitting the project team with a clear picture of the operations and costs associated with contractual obligations. Similar to the BCBSNC on-site analyses, it is important for all stakeholders to understand each step in the EDS claims

processing work. The following sections of the report details the EDS functional processes including costs attributable to processing a Medicaid claim which are also presented at the end of this section:

Provider Services Unit:

The Provider Services department consists of 60 full time staff who work in the Call Center, as part of the Knowledge Team, or as Travel Representatives. The Unit's functional responsibilities are as follows:

- Call Center Team - when fully staffed the Call Center consists of approximately 41 full-time equivalent (FTE) personnel. The staff is divided by subject areas of expertise who then take calls from providers through an automated call distribution system as well as process all of the USPS mail (sorting, date stamping, and special batching).
- Knowledge and Research Team – the team consists of 6 FTEs, including 2 trainers. The Team takes referrals from the DMA and deals with "hot" items, or issues that require more attention than the call center can provide. They conduct research on various claim or provider related issues as they arise. The Knowledge and Research Team also affords providers conferencing capabilities as required to obtain a necessary resolution.
- Travel Representatives – one supervisor and 12 field representatives cover the state. The representatives are contracted to hold up to 50 workshops each year. Representatives also receive referrals from DMA and calls from providers to conduct training for specific providers. Travel Representatives also develop content for their workshops and training exercises.

Medical Policy, File Maintenance and Adjustments Unit:

The Medical Policy/File Maintenance/Adjustments consists of three function areas that include support service efforts of approximately 27 FTEs as follows:

- Medical Policy Unit – This group is made up of 11 FTEs including six nurses and five non-nursing positions who support the DMA Medicaid claims processing contract. The Unit handles all suspended claims and reviews the claims, based on criteria as to the type of claim and as determined by Medicaid State and Federal guidelines. A detailed worksheet synopsis is prepared for each suspended claim worked by the Unit. These detailed worksheets are batched and sent to be data entered by an EDS sub-contractor (DSA). All claims must be resolved before payment is considered. The assigned nurses on occasion may address some adjustment referrals if the claim was denied or not paid in full. Staff assigned to this Unit also work directly with the DMA to update necessary CPT code information.
- File Maintenance Unit – This unit consists of approximately 5 FTEs. Its main responsibilities include updating claim reference files, auditing files, procedure codes, and applicable rates as required. The Unit works with the both the DMA and the EDS Systems Department on updating the system for changes in areas such as eligibility and audits as well as systems testing and user acceptance. The Unit receives memos from the DMA regarding any recent updates and changes that may be required. All changes that take place require a memo stating the applicable change, edit, audit, or update. The Unit receives approximately 300-400 change or edits and audit memos each year. The unit will act as a resource for Provider Services as well and works closely and frequently with the state Medical Policy staff on drafting the memos for any changes or updates.
- Adjustments Unit– EDS employs a total of 8 FTEs within their Adjustments Unit. The Unit receives submissions from providers for any adjustment requests either electronically or by paper via the USPS mail. The Adjustments Unit performs manual adjustments to all of the paper claims

as may be required. They receive approximately 3,500 pieces of mail each week, of which 2,500 might be adjustment related. The staff sorts and batches the adjustment requests and sends paper adjustments to the EDS sub-contractor, DSA who has the responsibility of keying the adjustments into system. The DSA sends batches back to the EDS Adjustments Unit where each batch is matched with its corresponding prepared worksheet.

Financial and Buy-In Unit:

The Financial and Buy-In Unit consists of one full-time manager, two FTEs working the Buy-In function, three FTE accountants, and four cash application personnel. The functional responsibilities of each of the Unit sections are as follows:

- The Accountants are required to prepare financial statements for the Medicaid claiming contract initiative and submit these statements to DMA periodically. Additionally accounting personnel address any recoupments as well as any withholdings that are not resolved systematically. This section also fields calls from both the DMA and providers regarding payment issues and/or tax questions.
- Cash Applications personnel apply all refunds sent back by providers. A detailed report is run and more commonly called a "refund batch". Cash Applications staff also receive anywhere from 50 to several hundred refunds each day. The Unit also receives state issued checks from the DMA with supporting documentation on where to apply these refunds within the EDS system. Lastly the Unit voids any refunded checks for any outstanding issues that may not be resolved.
- The staff assigned to the Buy-In function compares records from numerous agencies and verifies recipient eligibility.

Electronic Claims Submission Unit:

The Electronic Claims Submission Unit (ECS) employs a total of 10 full-time employees. Approximately 97% of all Medicaid claims are received electronically. The Unit's claims processing responsibilities are described below:

- The ECS Unit handles all incoming electronic claims. A recipient eligibility batch is run every two hours. Claims are received through EDS's proprietary system that ensures compliance with all HIPAA requirements. The automated system looks at each claim to make sure there is enough information to warrant processing a Medicaid claim and that each claim passes all mandated HIPAA standards. This Unit is not responsible for the claims audit function. Each provider receives verification through the system that their claim has been received and is notified if their claim is valid or has failed any of the systems preprogrammed requirements. The support staff assigned to this Unit consisting of 10FTEs, performs data retrieval services, tests on HIPAA transactions, and support calls for certain specific transactions. This group is also responsible for maintaining system mailbox IDs and passwords applicable to providers.
- ECS staff also supports the North Carolina Electronic Claims Submission (NCECS) web tool. They provide training, both locally and remotely, and support any NCECS functionality requirements.
- The ECS Unit supports the VAN (Value Added Network) system. VAN is a working system tool that provides instant feedback on the eligibility status of a potential Medicaid recipient. It is used primarily by doctor's offices and pharmacies. Most of EDS's work with VAN is up front during the contracting and set-up stages of the overall claiming function.

Paper Claims Unit:

Although EDS processes approximately 97% of all Medicaid claims electronically, the Paper Claims Unit, consisting of 12 FTEs handles anywhere between 200,000 to 400,000 paper claims

each month. The Unit handles all incoming and outgoing mail as it relates to Medicaid paper claims. Mail is sorted into buckets or trays and then separated by type of claim. Claims are scanned, then boxed and sent to an EDS sub-contractor (DSA) to be keyed into the system. Claims with errors are sent directly back to the providers for correction or additional information. Paper claims are housed for 60 days and then shredded, while all scanned claims are kept on CDs for the requisite records retention period as stipulated by the DMA.

Prior Approval Unit:

There are approximately 40 employees who work in the Prior Approval Unit. While in some instances, prior approval can be given over the phone for Long Term Care; all other prior approval must be in writing prior to any EDS involvement. All mail received by the Unit is sorted and batched into one of the following areas; Optical Dental and Orthodontic, Surgery, Enhanced Care, Hearing Aid, Therapeutic Leave, Long Term Care, and Durable Medical Equipment (DME). Unit analysts in each group or section sign out batches and review it based on the mandated criteria set forth by the DMA. Valid requests are keyed into the system and if approved, a copy is sent back to the provider. Any request that is denied or marked pending will get entered into the system at this time as well. Requests that are pending will be sent back to the providers letting them know that additional information is needed. Claim denials are sent back to the provider with a letter explaining their right to appeal the decision and the process involved.

Appeals are heard by the DMA, who has the authority to overturn the original decision. If a denial is overturned, DMA will send a notice to EDS, who will then enter the information into their system noting the decision of the appeal. Notice will be sent to the provider for any approved requests. Prior Approval staff consist primarily of reviewers who specialize in specific areas such as DME or Long Term Care (which must be reviewed by an RN or LPN), Denial Analysts who take calls from providers and assist with pending approvals, and clerical staff who receive, sort, and stamp mail, key data into system and perform filing duties on an as needed basis.

Pharmacy and Drug Rebate Unit:

The Pharmacy and Drug Rebate Unit is staffed by a Director and five full-time employees. The EDS staff works directly with their counterparts at DMA on claims processing, Point of Sale program and change of policy issues and resolutions. The Unit also reviews Pharmacy or Drug related paper claims, State report preparation, and any documents issued by the State and/or the DMA. At least three EDS staff focus primarily on rebates and address any issues that may apply to invoicing, daily deposits and reporting, claims adjustments, and recoupments. The DMA reviews all changes to these invoices. This department also works closely with the DMA on all matters related to policy, State government and Medicaid specific compliance.

EDS Systems Unit:

Overseen by the Unit's Technical Director, staffing for the Systems Unit consists of 25 FTEs. Approximately 10 FTEs focus on the systems infrastructure while 15 FTEs support all system-wide applications as well as the systems developer staff. Applications personnel work on the overall and general system support, claims conversion, weekly claims adjudication, and user related web browser screens. System developers work on changes received in memos from the DMA addressing issues of legislative mandates and new pharmaceutical or drug related matters.

The developers also perform testing for the system web site and research any new or forthcoming initiatives. The network supporters focus on the servers, back-up capabilities, the general maintenance of the system, as well as routine maintenance and support for the ECS department.

EDS COST OF SERVICES SUMMARY

All data requested applicable to claims counts and financial details supporting their contractual obligation to the DMA was received and easily disseminated. Although actual costs of the contract was provided in total, we were not able to obtain "specific" FY 2007 cost information as it pertained to assigned staff (salaries and benefits) as it applied directly to the initial claims processing function carried out in support of the DMA contract. This has limited us from segregating functional costs specific to claims processing similar to what we have depicted for NCBCBS. EDS did however provide us with actual costs of personnel for any of the additional contractual amendments that subsequently followed and applied to the fiscal year in review. Therefore, only the actual Fiscal Year 2007 costs applicable to any contract amendments were verified. These costs totaled $10,539,929.00 during Fiscal 2007, while the "base" contract costs totaling $34,954,130.00 were not verified to actual EDS payroll or financial support documentation. Contractual costs and actual claims processed for the Fiscal Year Ended June 30, 2007 were as follows:

- Financial Administration …… $ 133,227.00
- Prior Approval …… $ 809,195.00
- Finance Department …..…….. $ 206,908.00
- Pharmacy Operations Costs …… $ 153,548.00
- Medical Policy Operations Costs …….……. $ 527,712.00
- Provider Services Operations Costs …….……. $2,838,001.00
- ECS/Claims Operations Costs ……..…….. $ 190,800.00
- Systems Programming and Development Operations Cost …..…. $3,083,310.00
- NPI Project Costs ……... $2,144,963.00
- Other Claims Processing Costs ……..…. $ 452,260.00

Sub-total Amendment Costs …… $10,539,925.00

- FY 2007 Actual Costs – Base Contract (non-detailed) ...……..…..$34,954,130.00

Total Fiscal 2007 EDS Claims Processing Costs …….. $45,494,055.00
Total Fiscal 2007 Claims Processed …….. 51,844,698
Total Fiscal 2007 EDS Cost per Claim ……$ **0.88**
* Total Fiscal 2007 EDS Cost per Claim (Pharmacy Costs Excluded) ……$ **0.87**

CONTRACTOR SUPPORT

As part of MAXIMUS' contractual obligation under this study, we were required to document the administrative costs incurred by those entities contracting with each of the three claims processing contractors. As such, MAXIMUS project team members interviewed staff, obtained actual Fiscal Year 2007 cost data (where noted), internal control and Payment Error Rate Measurement (PERM) claims count reports provided by the contractors and verified all information to actual financial and statistical reports provided by each of the contractors (where noted). The sections below depict our analyses of the State Health Plan (SHP) support to BCBSNC as well as the Division of Medical Assistance support afforded to EDS. The SHP also provided some basic contract information for Medco but was limited into what they could provide due to strictly enforced contractual confidentiality arrangements. Our review determined the following:

STATE HEALTH PLAN

The project team met with key SHP personnel assigned to working the contractual arrangements entered into with both BCBSNC and Medco with regard to SCHIP claims processing. The project team was able to interview all SHP employees who played a role in supporting the Health Choice Special Needs claiming process at BCBSNC and Medco. While conducting our interviews at SHP, we met with the Directors of Customer Relations, Financial Services, and Pharmacy Benefits. It should be noted that although reasonable the SHP provided the "average" costs of each of their staff supporting the BCBSNC and Medco contracts rather than the "actual" Fiscal 2007 costs. The SHP supports these two contractors as follows:

SHP Financial Services:

The SHP Financial Services Division supports all claims related financial and statistical provisions stipulated in the BCBSNC and Medco contracts. The Director and two full-time staff support any and all financial operations attributable to the contract. Additionally, non-contractual responsibilities consist of SHP internal accounting and audit as well as any DMA reporting requirements. Financial Services personnel are responsible for the following activities:

- daily cash deposits from BCBS Health Choice
- journal entries
- payment of weekly medical claims
- processing and payment of bi-weekly pharmacy claims
- audit support for the SCHIP program
- month end closing for the SCHIP program
- year end audit for NC Health Choice claims
- prepare cash requisitions for the DMA, to draw down funds for medical claim disbursements

SHP Pharmacy Benefits Services:

The Director of Pharmacy Benefits has the sole responsibility of oversight of the Pharmacy Benefits Manager contract with Medco. The Director provides adjudication of claims support, in-house pharmacy projects, and all Pharmacy network operations.

Customer Relations Services:

One full-time SHP staff member assumes the role of supporting all customer relations tasks. This individual is tasked with answering questions on any claim that may arise, is involved in NC Health Choice committees. Lastly the individual ensures the accurate flow of information with contractors and how changes at SHP may affect NC Health Choice and providers.

SHP ADMINISTRATIVE SUPPORT COSTS:

As previously mentioned the MAXIMUS project team has not verified actual Fiscal Year 2007 expenditures in support of the BCBSNC or Medco contracts. What has been provided below represents only the "average" costs per staff person (detailed above). Additionally, the administrative cost per claim reflected is based solely on the actual claims counts provided and reflected in SHP records. The claims count varies slightly from the claims information provided by BCBSNC for SCHIP related claims. Therefore the total "average" administrative support costs afforded to the BCBSNC contract was $210,932.00 for FY 2007 and the "average" administrative support costs applicable to the Medco contract for the same period totaled $ 27,332.13. This equates to an average cost per claim of $.12/claim processed and $.04/claim processed respectively.

DIVISION OF MEDICAL ASSISTANCE

In order to find the true cost of processing claims, including administrative support related to the DMA's contract with EDS, the project team conducted interviews with some of the Directors at DMA who were found to support this claims processing arrangement. Our goal was to learn what services the DMA provided that specifically addressed and supported the EDS Medicaid claims processing contract. Additionally, the DMA supports BCBS in a similar manner with respect to SCHIP claims processed under their arrangement with the SHP. We spoke with the directors or managers of the following groups: MMIS, Recipient and Provider Services, Financial Management, Clinical Policy and Programs, and Budget Management. The following divisions/units provide yearly administrative support to the EDS, BCBS and Medco contracts:

Information Technology (IT) & HIPAA:

The IT & HIPAA staff consists of 23 full-time employees. Within this group, the Information Technology Manager oversees 11 Business and Technical Application analysts. This individual also spends approximately 25% of his time supporting the EDS claims processing contract. Correspondingly the technology mangers staff spends nearly 95% of their time providing support for the Medicaid program, of which only 10% is dedicated to supporting the EDS process and contractual obligations.

Within the IT and HIPPA group, the Decision Support IT Manager also oversees the data warehouse and all reporting analytics. BCBSNC sends detailed paid claims files to this group and receives all adjudicated claims from EDS upon completion. It is the responsibility of this group to create and update reports submitted to the State Legislature and Federal government.

HIPAA compliance issues are handled by another DMA senior staff member along with two full-time staff. The senior staff employee spends 70% of the time supporting the EDS claims process, while one of full-time staff devotes 100% of the time with EDS related activities. The

remaining full-time staff member acts as the Privacy Officer and also spends 100% of his time on the specific Medicaid program activities, with only10% of the time dedicated to the EDS claiming process.

An Assistant Director (AD) is assigned to oversee the daily operations of the MMIS team and the IT Infrastructure & Special IT Projects group. The AD spends approximately 60% of her time in support of the EDS contract, with the help of an assistant who spends roughly 90% of her time dedicated to the EDS contract. Responsibilities include contracts, amendments, and IT support. The MMIS team consists of three Business & Technical Applications Analysts who dedicate100% of their time supporting the EDS contract as well as three temporary employees who also support the contract 100%. DMA's MMIS team works regularly with assigned EDS claims processing and support personnel.

Recipient and Provider Services:

The Recipient & Provider Services Unit has approximately 35 staff members and is made up of four subdivisions: Claims Analysis, Provider Services/Enrollment, Medicaid Eligibility, and Eligibility Information System (EIS). The Enrollment and Medicaid Eligibility groups' work involves direct support for the EDS claiming contract and associated processes.

- Provider Services/Enrollment Team - consists of 13 FTEs and is under the direction of an Assistant Director. This team is responsible for enrolling all providers who wish to be a part of the Medicaid claiming program. The staff members receive all the information from the each applicant provider. They must then research and verify the entire provider supplied information for accuracy. Approximately 50% of their time is spent entering the information into the EDS MMIS system. Once a provider is enrolled, they are eligible to begin billing Medicaid.
- Recipient Eligibility Team - is responsible for writing the policy that all North Carolina counties must follow so that potential recipients can be enrolled in the Medicaid program. The assigned staff must research and review all Federal and State guidelines before updating the eligibility policy. This group is then supported by a team of 11 trainers who monitor the eligibility process at the county level throughout the State. The trainers create their own training manuals that include updates and changes in Medicaid eligibility policy. The trainers provide on-site training programs that are regularly scheduled at each county's location throughout the year. These DMA staff work closely with the Provider Services Unit at EDS. Two full-time DMA employees spend approximately 25% of their time with EDS on contract monitoring and to set up training seminars as may be required.

Finance Management:

The Finance department has the responsibility of setting all the Medicaid rates. The rate setting unit is overseen by a Director. The staff of 20 employees who spend their time reviewing cost reports, analyzing data, and ultimately updating the Medicaid rates. When the rates are updated, they are sent to EDS, SCHIP, and any other organization who utilize the rates. The rates are sent to the organizations as a Financial Operations document, or FO. An FO is in the form of a memo, as referenced in the File Maintenance Unit of EDS and could contain a single rate or multiple rates. New rates are also posted in a "bulletin" on the DMA web site.

The services performed by the Financial Management group benefit all parties that utilize Medicaid rates. Therefore, the costs associated with this group will not be included in either the EDS claim costs or the BCBS claim costs.

Clinical Policy and Programs Services:

Under the supervision of an Assistant Director the Clinical Policy and Program Services Unit carries out a number of services that benefit the Medicaid program as a whole. Their main responsibility is to conduct research and establish new program policies. The policies may address issues relating to clinical services, community care, behavioral health, pharmacy and related ancillary services, dental, and medical.

Specific to the EDS claims processing initiative, the policy staff will spend 25%-50% of their time on matters related to provider complaints, prior approval, billing, and eligibility.

Budget Management Services:

This unit is under the supervision of the Assistant Director of Budget who affords approximately 15% of her time supporting the EDS claims processing contract, while one full-time assistant contributes roughly 75% of her time on EDS claims processing related matters. Additionally, the Budget Management Unit employs several staff accountants whose responsibilities are to monitor both EDS Medicaid and BCBSNC Health Choice payments. The accountants also address most of the issues related to withholdings, repayments, cash advances, and repayment plans. A separate staff member works on the appeals process. When there is an appeal to an audit finding on a provider's cost report, this person will assist in communicating the finding proper as well as any potential positive or negative impact with the provider, set up a conference to hear the appeal, and conduct any additional correspondence that is necessary with regard to any findings.

DMA ADMINISTRATIVE SUPPORT COSTS:

Clearly the DMA affords administrative support services to both BCBSNC and EDS sub-contractors as previously stated above. As such, the MAXIMUS project team has provided the costs (including the cost per claim administrative support) for each of these contractors below. We should caution decision makers that although the DMA administrative support afforded the EDS claims processing contract in FY 2007 is considerably higher than that of BCBSNC SCHIP claiming initiative, there is no real comparison to be drawn given the significantly higher number of Medicaid claims processed by EDS as compared to the relatively small amount of claims (in comparison) for just the BCBSNC Health Choice claims. Therefore the total "average" administrative support costs afforded to the BCBS contract was $341,147.28 for FY 2007 and the "average" administrative support costs applicable to the EDS contract for the same period totaled $3,943,606.00. This equates to an average cost per claim of $.19/claim processed and $.08/claim processed respectively.

PHARMACY REBATES

Under separate agreements, both the Division of Medical Assistance and the State Health Plan take advantage of vendor rebates for pharmacy benefits utilized by their plan participants. The Division of Medical Assistance utilizes pharmacy claim processing services under contract with

Electronic Data Services. The State Health Plan contracts with Medco, a private vendor, to process SCHIP pharmacy claims. North Carolina General Statute 135-40.4a governs the confidentiality of the contract between Medco and the State Health Plan. As such, our analysis was conducted through a review of only the overall pharmacy rebates relative to the number of pharmacy claims paid over the July 2006 to June 2007 time period.

We do feel however that Federal rebates that could be realized by combining NCHC claims with the current DMA claim volume would have been greater than the $3,483,463.68 attained in FY 2007.

PERFORMANCE AUDIT

STATE CHILDREN'S HEALTH INSURANCE PROGRAM
CLAIMS PROCESSING

JULY 2007

“PERFORMANCE AUDIT, STATE CHILDREN’S HEALTH INSURANCE PROGRAM CLAIMS PROCESSING—JULY 2007”

Audit reports issued by the Office of the State Auditor can be obtained from the web site at www.ncauditor.net The above audit is referenced in the “State Children’s Health Insurance Program Administration” Report.

Title XXI Legislation

Amended by DC Appropriations Bill PL 105-100

SUBTITLE J--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

CHAPTER 1--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 4901. ESTABLISHMENT OF PROGRAM.

(a) ESTABLISHMENT- The Social Security Act is amended by adding at the end the following new title:

`TITLE XXI--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

`SEC. 2101. PURPOSE; STATE CHILD HEALTH PLANS.

`(a) PURPOSE- The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through--

`(1) obtaining coverage that meets the requirements of

section 2103, or

`(2) providing benefits under the State's medicaid plan under

title XIX,

or a combination of both.

`(b) STATE CHILD HEALTH PLAN REQUIRED- A State is not eligible for payment under section 2105 unless the State has submitted to the Secretary under section 2106 a plan that--

`(1) sets forth how the State intends to use the funds

provided under this title to provide child health assistance to

needy children consistent with the provisions of this title, and

`(2) has been approved under section 2106.

`(c) STATE ENTITLEMENT- This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

`(d) EFFECTIVE DATE- No State is eligible for payments under section 2105 for child health assistance for coverage provided for periods beginning before October 1, 1997.

`SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.

`(a) GENERAL BACKGROUND AND DESCRIPTION- A State child health plan shall include a description, consistent with the requirements of this title, of--

`(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2110(c)(2));

`(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

`(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage;

`(4) the child health assistance provided under the plan for targeted low-income children, including the proposed methods of delivery, and utilization control systems;

`(5) eligibility standards consistent with subsection (b);

`(6) outreach activities consistent with subsection (c); and

`(7) methods (including monitoring) used--

`(A) to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and

`(B) to assure access to covered services, including emergency services.

`(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY-

`(1) ELIGIBILITY STANDARDS-

`(A) IN GENERAL- The plan shall include a description of

the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

`(B) LIMITATIONS ON ELIGIBILITY STANDARDS- Such eligibility standards--

`(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

`(ii) may not deny eligibility based on a child having a preexisting medical condition.

`(2) METHODOLOGY- The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

`(3) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE PROGRAMS- The plan shall include a description of procedures to be used to ensure--

`(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

`(B) that children found through the screening to be

eligible for medical assistance under the State medicaid

plan under title XIX are enrolled for such assistance under

such plan;

`(C) that the insurance provided under the State child

health plan does not substitute for coverage under group

health plans;

`(D) the provision of child health assistance to targeted

low-income children in the State who are Indians (as

defined in section 4(c) of the Indian Health Care

Improvement Act, 25 U.S.C. 1603(c)); and

`(E) coordination with other public and private programs

providing creditable coverage for low-income children.

`(4) NONENTITLEMENT- Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

`(c) OUTREACH AND COORDINATION- A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

`(1) OUTREACH- Outreach to families of children likely to be eligible for child health assistance under the plan or under

other public or private health coverage programs to inform

these families of the availability of, and to assist them in

enrolling their children in, such a program.

`(2) COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS- Coordination of the administration of the State program under this title with other public and private health insurance programs.

`SEC. 2103. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE.

`(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE- The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

`(1) BENCHMARK COVERAGE- Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

`(2) BENCHMARK-EQUIVALENT COVERAGE- Health benefits coverage that meets the following requirements:

`(A) INCLUSION OF BASIC SERVICES- The coverage includes benefits for items and services within each of the

categories of basic services described in subsection (c)(1).

`(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE- The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

`(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE- With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

`(3) EXISTING COMPREHENSIVE STATE-BASED COVERAGE- Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

`(4) SECRETARY-APPROVED COVERAGE- Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

`(b) BENCHMARK BENEFIT PACKAGES- The benchmark benefit packages are as follows:

`(1) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE-

The standard Blue Cross/Blue Shield preferred provider option

service benefit plan, described in and offered under section

8903(1) of title 5, United States Code.

`(2) STATE EMPLOYEE COVERAGE- A health benefits coverage plan that is offered and generally available to State employees in the State involved.

`(3) COVERAGE OFFERED THROUGH HMO- The health insurance coverage plan that--

`(A) is offered by a health maintenance organization (as

defined in section 2791(b)(3) of the Public Health Service

Act), and

`(B) has the largest insured commercial, non-medicaid

enrollment of covered lives of such coverage plans offered

by such a health maintenance organization in the State

involved.

`(c) CATEGORIES OF SERVICES; DETERMINATION OF ACTUARIAL VALUE OF COVERAGE-

`(1) CATEGORIES OF BASIC SERVICES- For purposes of this section, the categories of basic services described in this

paragraph are as follows:

`(A) Inpatient and outpatient hospital services.

`(B) Physicians' surgical and medical services.

`(C) Laboratory and x-ray services.

`(D) Well-baby and well-child care, including

age-appropriate immunizations.

`(2) CATEGORIES OF ADDITIONAL SERVICES- For purposes of this section, the categories of additional services described in this paragraph are as follows:

`(A) Coverage of prescription drugs.

`(B) Mental health services.

`(C) Vision services.

`(D) Hearing services.

`(3) TREATMENT OF OTHER CATEGORIES- Nothing in this subsection shall be construed as preventing a State child

health plan from providing coverage of benefits that are not

within a category of services described in paragraph (1) or (2).

`(4) DETERMINATION OF ACTUARIAL VALUE- The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared--

`(A) by an individual who is a member of the American

Academy of Actuaries;

`(B) using generally accepted actuarial principles and methodologies;

`(C) using a standardized set of utilization and price factors;

`(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

`(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

`(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

`(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

`(5) CONSTRUCTION ON PROHIBITED COVERAGE- Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

`(d) DESCRIPTION OF EXISTING COMPREHENSIVE STATE-BASED COVERAGE-

`(1) IN GENERAL- A program described in this paragraph is a child health coverage program that--

`(A) includes coverage of a range of benefits;

`(B) is administered or overseen by the State and

receives funds from the State;

`(C) is offered in New York, Florida, or Pennsylvania; and

`(D) was offered as of the date of the enactment of this

title.

`(2) MODIFICATIONS- A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of--

`(A) the actuarial value of the coverage under the

program as of the date of the enactment of this title, or

`(B) the actuarial value described in subsection (a)(2)(B),

evaluated as of the time of the modification.

`(e) COST-SHARING-

`(1) DESCRIPTION; GENERAL CONDITIONS-

`(A) DESCRIPTION- A State child health plan shall include

a description, consistent with this subsection, of the

amount (if any) of premiums, deductibles, coinsurance, and

other cost sharing imposed. Any such charges shall be

imposed pursuant to a public schedule.

`(B) PROTECTION FOR LOWER INCOME CHILDREN- The State child health plan may only vary premiums, deductibles,

coinsurance, and other cost sharing based on the family

income of targeted low-income children in a manner that

does not favor children from families with higher income

over children from families with lower income.

`(2) NO COST SHARING ON BENEFITS FOR PREVENTIVE SERVICES- The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D).

`(3) LIMITATIONS ON PREMIUMS AND COST-SHARING-

`(A) CHILDREN IN FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE- In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose--

`(i) an enrollment fee, premium, or similar charge

that exceeds the maximum monthly charge permitted

consistent with standards established to carry out

section 1916(b)(1) (with respect to individuals

described in such section); and

`(ii) a deductible, cost sharing, or similar charge

that exceeds an amount that is nominal (as determined

consistent with regulations referred to in section

1916(a)(3), with such appropriate adjustment for

inflation or other reasons as the Secretary determines

to be reasonable).

`(B) OTHER CHILDREN- For children not described in

subparagraph (A), subject to paragraphs (1)(B) and (2), any

premiums, deductibles, cost sharing or similar charges

imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total

annual aggregate cost-sharing with respect to all targeted

low-income children in a family under this title may not

exceed 5 percent of such family's income for the year

involved.

`(4) RELATION TO MEDICAID REQUIREMENTS- Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2).

`(f) APPLICATION OF CERTAIN REQUIREMENTS-

`(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS-

`(A) IN GENERAL- Subject to subparagraph (B), the State

child health plan shall not permit the imposition of any

preexisting condition exclusion for covered benefits under

the plan.

`(B) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE- If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan

may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

`(2) COMPLIANCE WITH OTHER REQUIREMENTS- Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

`SEC. 2104. ALLOTMENTS.

`(a) APPROPRIATION; TOTAL ALLOTMENT- For the purpose of providing

allotments to States under this section, there is appropriated, out

of any money in the Treasury not otherwise appropriated-- `(1) for fiscal year 1998, $4,295,000,000;

`(2) for fiscal year 1999, $4,275,000,000;

`(3) for fiscal year 2000, $4,275,000,000;

`(4) for fiscal year 2001, $4,275,000,000;

`(5) for fiscal year 2002, $3,150,000,000;

`(6) for fiscal year 2003, $3,150,000,000;

`(7) for fiscal year 2004, $3,150,000,000;

`(8) for fiscal year 2005, $4,050,000,000;

`(9) for fiscal year 2006, $4,050,000,000; and

`(10) for fiscal year 2007, $5,000,000,000.

`(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA-

`(1) IN GENERAL- Subject to paragraph (4) and subsection (d), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under

subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of--

`(A) the product of (i) the number of children described

in paragraph (2) for the State for the fiscal year and (ii)

the State cost factor for that State (established under

paragraph (3)); to

`(B) the sum of the products computed under subparagraph

(A).

`(2) NUMBER OF CHILDREN-

`(A) IN GENERAL- The number of children described in this

paragraph for a State for--

`(i) each of fiscal years 1998 through 2000 is equal

to the number of low-income children in the State with

no health insurance coverage for the fiscal year;

`(ii) fiscal year 2001 is equal to--

`(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

`(II) 25 percent of the number of low-income children in the

State for the fiscal year; and

`(iii) each succeeding fiscal year is equal to--

`(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

`(II) 50 percent of the number of low-income children in the

State for the fiscal year.

`(B) DETERMINATION OF NUMBER OF CHILDREN- For purposes of subparagraph (A), a determination of the number of

low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

`(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS-

`(A) IN GENERAL- For purposes of paragraph (1)(A)(ii),

the `State cost factor' for a State for a fiscal year equal

to the sum of--

`(i) 0.15, and

`(ii) 0.85 multiplied by the ratio of--

`(I) the annual average wages per employee for the State for such

year (as determined under subparagraph (B)), to

`(II) the annual average wages per employee for the 50 States and the District of Columbia.

`(B) ANNUAL AVERAGE WAGES PER EMPLOYEE- For purposes of subparagraph (A), the `annual average wages per employee' for a State, or for all the States. for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

`(4) FLOOR FOR STATES- In no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than $2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below $2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

`(c) ALLOTMENTS TO TERRITORIES-

`(1) IN GENERAL- Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsection (d), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

`(2) PERCENTAGE- The percentage specified in this paragraph for--

`(A) Puerto Rico is 91.6 percent,

`(B) Guam is 3.5 percent,

`(C) the Virgin Islands is 2.6 percent,

`(D) American Samoa is 1.2 percent, and

`(E) the Northern Mariana Islands is 1.1 percent.

`(3) COMMONWEALTHS AND TERRITORIES- A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

`(A) Puerto Rico.

`(B) Guam.

`(C) The Virgin Islands.

`(D) American Samoa.

`(E) The Northern Mariana Islands.

`(d) CERTAIN MEDICAID EXPENDITURES COUNTED AGAINST INDIVIDUAL STATE ALLOTMENTS- The amount of the allotment otherwise provided to a State under subsection (b) or (c) for a fiscal year shall be reduced by the sum of--

`(1) the amount (if any) of the payments made to that State under section 1903(a) for expenditures claimed by the State

during such fiscal year that is attributable to the provision of medical assistance to a child during a presumptive eligibility period under section 1920A, and

`(2) the amount (if any) of the payments made to that State under section 1903(a) for expenditures claimed by the State during such fiscal year that is attributable to the provision of medical assistance to a child for which payment is made under section 1903(a)(1) on the basis of an enhanced FMAP under the fourth sentence of section 1905(b).

`(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOTTED- Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallotted to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted.

`(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS- The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that have fully expended the amount of their allotments under this section.

`SEC. 2105. PAYMENTS TO STATES.

`(a) IN GENERAL- Subject to the succeeding provisions of this

section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104 (taking into account any adjustment under section 2104(d)), an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter--

`(1) for child health assistance under the plan for targeted

low-income children in the form of providing health benefits

coverage that meets the requirements of section 2103; and

`(2) only to the extent permitted consistent with subsection (c)--

`(A) for payment for other child health assistance for targeted low-income children;

`(B) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

`(C) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

`(D) for other reasonable costs incurred by the State to

administer the plan.

`(b) ENHANCED FMAP- For purposes of subsection (a), the `enhanced FMAP', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

`(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES-

`(1) GENERAL LIMITATIONS- Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

`(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE-

`(A) IN GENERAL—Except as provided in this paragraph, payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a fiscal year to the extent the total of such expenditures (for which payment is made under such subsection) exceeds 10 percent of the sum of—

‘‘(i) the total of such expenditures for such fiscal year, and

‘‘(ii) the total expenditures for medical assistance by the State under title XIX for which Federal payments made under section 1903(a)(1) are based on an enhanced FMAP described in section 2105(b) for such fiscal year.’’

`(B) WAIVER AUTHORIZED FOR COST-EFFECTIVE ALTERNATIVE-

The limitation under subparagraph (A) on expenditures for

items described in subsection (a)(2) shall not apply to the

extent that a State establishes to the satisfaction of the

Secretary that--

`(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103;

`(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and `(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.

`(3) WAIVER FOR PURCHASE OF FAMILY COVERAGE- Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that--

`(A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and `(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

`(4) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT-

Amounts provided by the Federal Government, or services

assisted or subsidized to any significant extent by the Federal

Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

`(5) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS AND OTHER COST-SHARING- For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost-sharing received by the State.

`(6) PREVENTION OF DUPLICATIVE PAYMENTS-

`(A) OTHER HEALTH PLANS- No payment shall be made to a

State under this section for expenditures for child health

assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

`(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS- Except as otherwise provided by law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

`(7) LIMITATION ON PAYMENT FOR ABORTIONS-

`(A) IN GENERAL- Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that

includes coverage of abortion.

`(B) EXCEPTION- Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

`(C) RULE OF CONSTRUCTION- Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

`(d) MAINTENANCE OF EFFORT-

`(1) IN MEDICAID ELIGIBILITY STANDARDS- No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

`(2) IN AMOUNTS OF PAYMENT EXPENDED FOR CERTAIN STATE-FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN-

`(A) IN GENERAL- The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which--

`(i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than

`(ii) the total of such expenditures in fiscal year 1996.

`(B) STATE CHILDREN'S HEALTH INSURANCE EXPENDITURES- The term `State children's health insurance expenditures' means the following:

`(i) The State share of expenditures under this title.

`(ii) The State share of expenditures under title XIX

that are attributable to an enhanced FMAP under section

1905(u).

`(iii) State expenditures under health benefits

coverage under an existing comprehensive State-based

program, described section 2103(d).

`(e) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT- The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

‘(f) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this section or subsections (e) and (f) of section 2104 shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.’

`SEC. 2106. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS.

`(a) INITIAL PLAN-

`(1) IN GENERAL- As a condition of receiving payment under section 2105, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

`(2) APPROVAL- Except as the Secretary may provide under

subsection (e), a State plan submitted under paragraph (1)--

`(A) shall be approved for purposes of this title, and

`(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.

`(b) PLAN AMENDMENTS-

`(1) IN GENERAL- A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

`(2) APPROVAL- Except as the Secretary may provide under

subsection (e), an amendment to a State plan submitted under

paragraph (1)--

`(A) shall be approved for purposes of this title, and

`(B) shall be effective as provided in paragraph (3).

`(3) EFFECTIVE DATES FOR AMENDMENTS-

`(A) IN GENERAL- Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

`(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS-

`(i) NOTICE REQUIREMENT- Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

`(ii) TIMELY TRANSMITTAL- Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

`(C) OTHER AMENDMENTS- Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end

of such fiscal year (or, if later, the end of the 90-day

period on which it becomes effective) unless the amendment

has been transmitted to the Secretary.

`(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS-

`(1) PROMPT REVIEW OF PLAN SUBMITTALS- The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

`(2) 90-DAY APPROVAL DEADLINES- A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

`(3) CORRECTION- In the case of a disapproval of a plan or

plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

`(d) PROGRAM OPERATION-

`(1) IN GENERAL- The State shall conduct the program in

accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

`(2) VIOLATIONS- The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

`(e) CONTINUED APPROVAL- An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

`SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

`(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS-

`(1) DESCRIPTION- A State child health plan shall include a

description of--

`(A) the strategic objectives,

`(B) the performance goals, and

`(C) the performance measures,

the State has established for providing child health assistance

to targeted low-income children under the plan and otherwise

for maximizing health benefits coverage for other low-income

children and children generally in the State.

`(2) STRATEGIC OBJECTIVES- Such plan shall identify specific strategic objectives relating to increasing the extent of

creditable health coverage among targeted low-income children and other low-income children.

`(3) PERFORMANCE GOALS- Such plan shall specify one or more performance goals for each such strategic objective so identified.

`(4) PERFORMANCE MEASURES- Such plan shall describe how performance under the plan will be--

`(A) measured through objective, independently verifiable

means, and

`(B) compared against performance goals, in order to

determine the State's performance under this title.

`(b) RECORDS, REPORTS, AUDITS, AND EVALUATION-

`(1) DATA COLLECTION, RECORDS, AND REPORTS- A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

`(2) STATE ASSESSMENT AND STUDY- A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).

`(3) AUDITS- A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

`(c) PROGRAM DEVELOPMENT PROCESS- A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

`(d) PROGRAM BUDGET- A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries.

`(e) APPLICATION OF CERTAIN GENERAL PROVISIONS- The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

`(1) TITLE XIX PROVISIONS-

`(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

`(B) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

`(C) Section 1903(w) (relating to limitations on provider taxes and donations).

`(2) TITLE XI PROVISIONS-

`(A) Section 1115 (relating to waiver authority).

`(B) Section 1116 (relating to administrative and

judicial review), but only insofar as consistent with this

title.

`(C) Section 1124 (relating to disclosure of ownership

and related information).

`(D) Section 1126 (relating to disclosure of information

about certain convicted individuals).

`(E) Section 1128A (relating to civil monetary penalties).

`(F) Section 1128B(d) (relating to criminal penalties for

certain additional charges).

`(G) Section 1132 (relating to periods within which

claims must be filed).

`SEC. 2108. ANNUAL REPORTS; EVALUATIONS.

`(a) ANNUAL REPORT- The State shall--

`(1) assess the operation of the State plan under this title

in each fiscal year, including the progress made in reducing

the number of uncovered low-income children; and

`(2) report to the Secretary, by January 1 following the end

of the fiscal year, on the result of the assessment.

`(b) STATE EVALUATIONS-

`(1) IN GENERAL- By March 31, 2000, each State that has a

State child health plan shall submit to the Secretary an

evaluation that includes each of the following:

`(A) An assessment of the effectiveness of the State plan

in increasing the number of children with creditable health

coverage.

`(B) A description and analysis of the effectiveness of

elements of the State plan, including--

`(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State

plan ends,

`(ii) the quality of health coverage provided including the types of benefits provided,

`(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

`(iv) the service area of the State plan,

`(v) the time limits for coverage of a child under the State plan,

`(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

`(vii) the sources of non-Federal funding used in the State plan.

`(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

`(D) A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

`(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

`(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

`(G) Recommendations for improving the program under this title.

`(H) Any other matters the State and the Secretary consider appropriate.

`(2) REPORT OF THE SECRETARY- The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

`SEC. 2109. MISCELLANEOUS PROVISIONS.

`(a) RELATION TO OTHER LAWS-

`(1) HIPAA- Health benefits coverage provided under section 2101(a)(1) (and coverage provided under a waiver under section 2105(c)(2)(B)) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title II of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

`(2) ERISA- Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(a)(1)).

`SEC. 2110. DEFINITIONS.

`(a) CHILD HEALTH ASSISTANCE- For purposes of this title, the term `child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

`(1) Inpatient hospital services.

`(2) Outpatient hospital services.

`(3) Physician services.

`(4) Surgical services.

`(5) Clinic services (including health center services) and

other ambulatory health care services.

`(6) Prescription drugs and biologicals and the

administration of such drugs and biologicals, only if such

drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

`(7) Over-the-counter medications.

`(8) Laboratory and radiological services.

`(9) Prenatal care and prepregnancy family planning services and supplies.

`(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

`(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community- based services.

`(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

`(13) Disposable medical supplies.

`(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

`(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services,

and respiratory care services) in a home, school, or other setting.

`(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

`(17) Dental services.

`(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

`(19) Outpatient substance abuse treatment services.

`(20) Case management services.

`(21) Care coordination services.

`(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

`(23) Hospice care.

`(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--

`(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

`(B) performed under the general supervision or at the direction of a physician, or

`(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

`(25) Premiums for private health care insurance coverage.

`(26) Medical transportation.

`(27) Enabling services (such as transportation, translation,

and outreach services) only if designed to increase the

accessibility of primary and preventive health care services for eligible low-income individuals.

`(28) Any other health care services or items specified by the Secretary and not excluded under this section.

`(b) TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

`(1) IN GENERAL- Subject to paragraph (2), the term `targeted low-income child' means a child--

`(A) who has been determined eligible by the State for

child health assistance under the State plan;

`(B)(i) who is a low-income child, or

`(ii) is a child— ‘‘(I) whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level;

(II) whose family income (as so determined) does not exceed the medicaid applicable income level (as defined in paragraph (4) but determined as if ‘June 1, 1997’ were substituted for ‘March 31, 1997’); or

‘‘(III) who resides in a State that does not have a medicaid applicable income level (as defined in paragraph (4)); and

`(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

`(2) CHILDREN EXCLUDED- Such term does not include--

`(A) a child who is an inmate of a public institution or

a patient in an institution for mental diseases; or

`(B) a child who is a member of a family that is eligible

for health benefits coverage under a State health benefits

plan on the basis of a family member's employment

with a public agency in the State.

`(3) SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

`(4) MEDICAID APPLICABLE INCOME LEVEL- The term `medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of March 31, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) or 1905(n)(2) (as selected by a State) for the age of such child.

`(c) ADDITIONAL DEFINITIONS- For purposes of this title:

`(1) CHILD- The term `child' means an individual under 19

years of age.

`(2) CREDITABLE HEALTH COVERAGE- The term `creditable health coverage' has the meaning given the term `creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

`(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms `group health plan', `group health insurance coverage', and `health insurance coverage' have the meanings given such terms in section 2791 of the Public Health Service Act.

`(4) LOW-INCOME- The term `low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

`(5) POVERTY LINE DEFINED- The term `poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

`(6) PREEXISTING CONDITION EXCLUSION- The term `preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

`(7) STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms `State child health plan' and `plan' mean a State child health plan approved under section 2106.

`(8) UNCOVERED CHILD- The term `uncovered child' means a child that does not have creditable health coverage.'.

(b) CONFORMING AMENDMENTS-

(1) DEFINITION OF STATE- Section 1101(a)(1) is amended--

(A) by striking `and XIX' and inserting `XIX, and XXI', and

(B) by striking `title XIX' and inserting `titles XIX and

XXI'.

(2) TREATMENT AS STATE HEALTH CARE PROGRAM- Section 1128(h)

(42 U.S.C. 1320a-7(h)) is amended by--

(A) in paragraph (2), by striking `or' at the end;

(B) in paragraph (3), by striking the period and

inserting `, or'; and

(C) by adding at the end the following:

`(4) a State child health plan approved under title XXI.'.

CHAPTER 2--EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID

SEC. 4911. OPTIONAL USE OF STATE CHILD HEALTH ASSISTANCE FUNDS FOR ENHANCED MEDICAID MATCH FOR EXPANDED MEDICAID ELIGIBILITY.

(a) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR EXPANDED COVERAGE OF TARGETED LOW-INCOME CHILDREN- Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 4702(a)(2), is amended--

(1) in subsection (b), by adding at the end the following new

sentence: `Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).'; and

(2) by adding at the end the following new subsection:

`(u)(1) The conditions described in this paragraph for a State

plan are as follows:

`(A) The State is complying with the requirement of section

2105(d)(1).

`(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b) and section 2104(d).

`(2)(A) For purposes of subsection (b), the expenditures

described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

`(B) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(1)(D)).

`(3) For purposes of subsection (b), the expenditures described

in this paragraph are expenditures for medical assistance for

children who are born before October 1, 1983, and who would be

described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under

the State plan under this title based on such State plan as in

effect as of March 31, 1997.'.

(4) The limitations on payment under subsections (f) and (g) of section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).

(b) ESTABLISHMENT OF OPTIONAL ELIGIBILITY CATEGORY- Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 4733, is amended--

(1) in subclause (XII), by striking `or' at the end;

(2) in subclause (XIII), by adding `or' at the end; and

(3) by adding at the end the following:

`(XIV) who are optional targeted low-income children described in section 1905(u)(2)(C);'.

(c) EFFECTIVE DATE- The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

SEC. 4912. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) IN GENERAL- Title XIX of the Social Security Act is amended by inserting after section 1920 the following new section:

`PRESUMPTIVE ELIGIBILITY FOR CHILDREN

`SEC. 1920A.

(a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a

child during a presumptive eligibility period.

`(b) For purposes of this section:

`(1) The term `child' means an individual under 19 years of

age.

`(2) The term `presumptive eligibility period' means, with

respect to a child, the period that--

`(A) begins with the date on which a qualified entity

determines, on the basis of preliminary information, that

the family income of the child does not exceed the

applicable income level of eligibility under the State

plan, and

`(B) ends with (and includes) the earlier of--

`(i) the day on which a determination is made with

respect to the eligibility of the child for medical

assistance under the State plan, or

`(ii) in the case of a child on whose behalf an

application is not filed by the last day of the month

following the month during which the entity makes the

determination referred to in subparagraph (A), such

last day.

`(3)(A) Subject to subparagraph (B), the term `qualified

entity' means any entity that--

`(i)(I) is eligible for payments under a State plan

approved under this title and provides items and services

described in subsection (a) or (II) is authorized to

determine eligibility of a child to participate in a Head

Start program under the Head Start Act (42 U.S.C. 9821 et

seq.), eligibility of a child to receive child care

services for which financial assistance is provided under

the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to

receive assistance under the special supplemental nutrition

program for women, infants, and children (WIC) under

section 17 of the Child Nutrition Act of 1966 (42 U.S.C.

1786); and

`(ii) is determined by the State agency to be capable of

making determinations of the type described in paragraph

(1)(A).

`(B) The Secretary may issue regulations further limiting

those entities that may become qualified entities in order to

prevent fraud and abuse and for other reasons.

`(C) Nothing in this section shall be construed as preventing

a State from limiting the classes of entities that may become

qualified entities, consistent with any limitations imposed

under subparagraph (B).

`(c)(1) The State agency shall provide qualified entities with--

`(A) such forms as are necessary for an application to be

made on behalf of a child for medical assistance under the

State plan, and

`(B) information on how to assist parents, guardians, and

other persons in completing and filing such forms.

`(2) A qualified entity that determines under subsection

(b)(1)(A) that a child is presumptively eligible for medical

assistance under a State plan shall--

`(A) notify the State agency of the determination within 5

working days after the date on which determination is made, and

`(B) inform the parent or custodian of the child at the time

the determination is made that an application for medical

assistance under the State plan is required to be made by not

later than the last day of the month following the month during

which the determination is made.

`(3) In the case of a child who is determined by a qualified

entity to be presumptively eligible for medical assistance under a

State plan, the parent, guardian, or other person shall make

application on behalf of the child for medical assistance under

such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

`(d) Notwithstanding any other provision of this title, medical

assistance for items and services described in subsection (a) that--

`(1) are furnished to a child--

`(A) during a presumptive eligibility period,

`(B) by a entity that is eligible for payments under the

State plan; and

`(2) are included in the care and services covered by a State

plan; shall be treated as medical assistance provided by such plan for purposes of section 1903.'.

(b) CONFORMING AMENDMENTS-

(1) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended

by inserting before the semicolon at the end the following:

`and provide for making medical assistance for items and

services described in subsection (a) of section 1920A available

to children during a presumptive eligibility period in

accordance with such section'.

(2) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is

amended by inserting before the period at the end the

following: `or for items and services described in subsection

(a) of section 1920A provided to a child during a presumptive

eligibility period under such section'.

(c) EFFECTIVE DATE- The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4913. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED

CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL- Section 1902(a)(10)(A)(i)(II) (42 U.S.C.

1396a(a)(10)(A)(i)(II)) is amended by inserting `(or were being

paid as of the date of the enactment of section 211(a) of the

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)) and would continue to be paid but for the enactment of that section' after `title XVI'.

(b) EFFECTIVE DATE- The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

Title XXI Summary

of the Balanced Budget Act 1997-PL 105-33

BALANCED BUDGET ACT OF 1997

PUBLIC LAW 105-33

SUBTITLE J--STATE CHILDREN 'S HEALTH INSURANCE PROGRAM

Chapter 1--State Children 's Health Insurance Program

Establishment of Program (Section 4901)

Provision

oAmends the Social Security Act to add a new title--Title XXI--State Children's Health Insurance Program. The provisions described below list the section numbers of the new title XXI.

"Section 2101 Purpose; State Child Health Plans "

Provision

oThe purpose is to enable States to initiate and expand child health assistance to uninsured, low-income children. Such assistance should be provided primarily through either or both of two methods: (1) a program to obtain health insurance coverage that meets requirements in Section 2103 relating to the amount, duration, and scope of benefits; or (2) expanding eligibility for children under the State's Medicaid program. In order to be eligible for funds, States must submit to, and obtain approval from, the Secretary for a State Child Health Plan. This program is a capped entitlement for States.

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2102 General Contents of State Child Health Plan; Eligibility; Outreach "

Provisions

oA State Child Health Plan must include general background on the extent children currently have coverage, current State efforts to obtain coverage, how the plan will be coordinated with other efforts, proposed delivery methods and methods to assure quality and access to covered services.

oA State Child Health Plan must describe standards and methods used to establish andcontinue eligibility and enrollment for targeted low-income children. The standards must cover lower income children within a category of covered children before higher income children and may not deny eligibility based on a preexisting condition. It also must include a description of screening procedures to ensure that: only targeted low-income children receive assistance; Medicaid-eligible children are enrolled in Medicaid; this assistance does not substitute for group coverage; eligible Indian children receive assistance; and that there is coordination with other programs.

oA State Child Health Plan must describe procedures for outreach to families of children likely to be eligible for assistance under the Plan or under other public or private coverage and to inform them of the availability of, and assist in, enrollment in these programs.

oThe Plan must describe coordination of the State program with other public and private insurance programs.

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2103 Coverage Requirements for Children 's Health Insurance "

Provisions

oChild Health Assistance (other than Medicaid), for a targeted low-income child must consist of at least any of the following:

(1) Benchmark Coverage--Benefit plans must be equivalent to: the standard Blue Cross/Blue Shield Preferred Provider option offered under the Federal Employees Health Benefits Program (FEHBP); a health benefits plan that is offered and generally is available to State employees; and the HMO plan with the largest commercial enrollment in the State.

(2) Benchmark-Equivalent Coverage- The health benefit coverage must have an aggregate actuarial value that is at least equivalent to one of the benchmark packages. The coverage must include benefits in the following categories of basic services: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations. The coverage also must be at least 75 percent of the actuarial value of the benchmark package value for each of the following additional services: prescription drugs, mental health, vision, and hearing services.

(3) Existing Comprehensive State-Based Coverage-- Health Benefit coverage under anexisting comprehensive State-wide program is defined as a program that: provides a range of benefits; is administered by the State and receives State funds; is offered in New York, Florida or Pennsylvania; was offered on the date of enactment of this title and, if modified, still includes a range of benefits and has an actuarial value equal to, or greater than, either its value on August 5, 1997 or the value of one of the benchmark benefit packages.

(4) Secretary-Approved Coverage--Any other coverage that the Secretary determines provides appropriate coverage for targeted low-income children.

oA State Child Health Plan must include a description of the amount (if any) of cost-sharing and must be in accordance with a public schedule. For States using Medicaid, Medicaid limits apply. Cost-sharing may be varied only based on income in a manner that does not favor higher-income children over lower-income children. No cost-sharing is permitted for well-baby and well-child care, including age-appropriate immunizations. Cost-sharing for children in families with income at or below 150 percent of poverty must be consistent with Medicaid. Cost-sharing for children with

income above 150 percent of poverty must be based on an income-related sliding scale and the annual aggregate for all children in a family cannot exceed 5 percent of the family's income.

oThe State Child Health Plan may not impose pre-existing condition exclusions for covered benefits. States that provide for benefits through a group health plan or group health insurance coverage may permit pre-existing condition exclusions as allowed under the applicable section of the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA).

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2104 Allotments "

Provisions

oTotal allotments are: $4.275 billion for fiscal years 1998-2001; $3.15 billion for fiscal years 2002-2004; $4.05 billion for fiscal years 2005-2006; and $5 billion for fiscal year 2007. For each fiscal year, .25 percent of the total allotment must be allocated to the territories. In addition, $60 million of the total allotment is to be used for the special diabetes programs (see Sections 4921 and 4922).

oIn fiscal years 1998-2000, each State with an approved Child Health Plan will receive an allotment based on the State's proportion of the total number of low-income (less than200 percent of poverty) uninsured children multiplied by a geographic cost factor. For fiscal years 2001-2007, States will receive their allotment based on their proportion of a blended number of low-income uninsured and insured children multiplied by a geographic cost factor.

oFor 2001, the blended number of low-income uninsured and insured children is equal to the sum of two factors: (1) 75 percent of the number of low-income uninsured children in the State; and (2) 25 percent of the number of low-income children in the State. For each succeeding year, the blended number of low-income uninsured and insured children is equal to the sum of two factors: (1) 50 percent of the number of low-income uninsured children in the State; and (2) 50 percent of the number of low-income children in the State. The geographic cost factor is based on annual wages in the health care industry. The number of children is calculated as a 3-year rolling average from the most recent March supplements of the Current Population Survey data sets.

oEach State will receive a minimum floor of $2 million. Amounts allotted to a State will be available for 3 years. Any amounts unused after 3 years will be redistributed to States that have fully spent their allotments.

oThe territories will receive .25 percent of the total yearly allotments, to be divided among Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands in the following manner:

+Puerto Rico receives 91.6 percent;

+ Guam receives 3.5 percent;

+ the Virgin Islands receive 2.6 percent;

+ American Samoa receives 1.2 percent; and

+ the Northern Mariana Islands receive 1.1 percent.

oThe amount of a State's allotment will be reduced by the amount of Federal payments based on the State's expenditures for: (1) periods of presumptive Medicaid eligibility for children under section 1920A; (2) Medicaid coverage described in section 1902(u)(2); and (3) Medicaid coverage for children under age 19, born before October 1, 1983, who would not have been eligible under the Medicaid State plan as of April 15, 1997, described in section 1902(u)(3).

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2105 Payment to States "

Provisions

oThe Secretary will make payments to States with approved Child Health Plans for child health assistance for targeted low-income children who meet the coverage requirements in Section 2103, after reducing for expenditures for presumptive eligibility and for targeted low-income children under Medicaid. No more than 10 percent of a State's payments may be used for the total costs of: other child health assistance for targeted low-income children; health services initiatives; outreach; and administrative costs.

oThe enhanced Federal medical assistance percentage (FMAP) for child health assistance provided under this title is equal to the current FMAP increased by 30 percent of the difference between 100 and the current FMAP. The enhanced FMAP may not exceed 85 percent. Federal funds, premiums, other cost-sharing, provider taxes and donations cannot be used for the State matching requirements.

oThe Secretary may waive the 10 percent limitation for coverage meeting the benefits requirements of Section 2103 that she deems is a cost effective alternative and is provided through contracts with health centers receiving funds under section 330 of the Public Health Service Act or through disproportionate share hospitals. The Secretary also may allow payment to a State for the purchase of family coverage under a group health plan if the State establishes to her satisfaction that it is cost-effective and it would not substitute for existing coverage.

oNo payment may be made for expenditures that would have been made under private coverage or under any Federally-operated/financed program other than an IHS-operated or -financed program.

oIn addition, payments may not be used to pay for abortions or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion. Exceptions are provided for abortions that are necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. This would

not prevent a State, locality or private person or private funds from purchasing coverage that includes abortions.

oStates will not receive any payments for child health assistance if they adopt income and resource standards and methodologies for determining a child's eligibility for Medicaid that are more restrictive that those in effect on June 1, 1997. A State's allotment will be reduced by the amount by which the total of the State's children's health insurance expenditures in the preceding year is less than such expenditures in 1996. State children's health insurance expenditures are defined as the State share under this title, the State share under Medicaid attributable to an enhanced FMAP, and State expenditures for the"existing comprehensive State-based coverage."

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2106 Process for Submission, Approval and Amendment of State Child Health Plans "

Provisions

oIn order to receive funds under this title, a State must submit and obtain approval from the Secretary of its Child Health Plan. No funds are available prior to October 1, 1997. A State may submit an amendment to its Child Health Plan at any time. Any amendment that restricts or eliminates eligibility may not take effect unless the State certifies that it has provided prior public notice of the change and will not be effective for longer than 60 days unless it has been transmitted to the Secretary during the 60 day period. Other types of amendments will not remain in effect after the fiscal year (or, if later, the end of a 90 day period) unless the amendment has been transmitted to the Secretary.

oA State Child Health Plan or plan amendment is deemed approved unless the Secretary notifies the State in writing within 90 days after receiving the plan or amendment, that it is disapproved or that additional information is needed. The Secretary must provide a reasonable period for correction in the case of a disapproval.

oStates must conduct the program in accordance with the approved plan and plan amendments. The Secretary must establish a process for enforcing the requirements under this title, including withholding funds in the case of substantial noncompliance. The Secretary must provide a reasonable period of correction before taking financial sanctions.

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2107 Strategic Objectives and Performance Goals; Plan Administration "

Provisions

oA State Child Health Plan must include a description of strategic objectives, performance goals and performance measures for providing child health assistance to targeted low-income children and for maximizing health benefits coverage for other low-income children and children generally in the State. The Plan must describe how performance measures will be assessed through objective, independently verifiable means and compared against performance goals.

oA State Child Health Plan must include an assurance that the State will collect data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. It also must describe the State's plan for annual assessments, reports, and evaluations and assure the Secretary access to records for audit purposes.

oA State Child Health Plan must include a description of its process for involving the public in the design and implementation of the plan, as well as for ongoing public involvement. There must also be a description of the budget for the Plan.

oMedicaid provisions relating to conflict of interest, limitations on payment, and limits on provider taxes and donations apply to this title. In addition, a number of fraud and abuse provisions of title XI of the Social Security Act apply to this title.

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

"Section 2108 Annual Reports; Evaluations "

Provisions

oThe State must assess the operation of the State plan, including progress made in reducing the number of uncovered low-income children and report annually to the Secretary by January 1.

oBy March 31, 2000, each State with an approved State Child Health Plan must submit to the Secretary an evaluation addressing: the State's effectiveness in increasing the number of children with creditable coverage; the effectiveness of other elements of the State's Plan, including characteristics of children served, quality, amount and level of assistance, service area, time limits, coverage and other sources of non-Federal funding; the effectiveness of other public and private programs in increasing the availability of affordable quality health coverage; the State's coordination between other public and private programs for children; an analysis of the changes and trends that affect affordable, accessible coverage for children; the State's plans for improving the availability of children's coverage; recommendations for improving the State's program; and other matters the State and Secretary deem appropriate.

oThe Secretary must submit a report based on the State evaluations to Congress by December 31, 2001.

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

“Section 2109 Miscellaneous Provisions ”

Provision

oCoverage other than Medicaid will be considered creditable coverage for purposes of HIPAA. ERISA will not be affected by this title.

“Section 2110 Definitions ”

Provisions

oThe following terms are defined: child health assistance; targeted low-income child; child; creditable health coverage; group health plan; health insurance coverage; low-income; poverty line; preexisting condition exclusion; State Child Health Plan; and uncovered child.

oThe term “targeted low-income child” means a child who: meets the eligibility standards set by the State; resides in a family with income below the greater of the following: 200 percent of poverty or 50 percentage points above the Medicaid eligibility limit; and is not eligible for Medicaid or other health insurance coverage. An exception is that the term may include children covered under a health insurance coverage program in operation since before July 1, l997 that is offered by the State and receives no Federal funds. Children excluded are those who: are inmates of public institutions; patients in an institution for mental diseases (IMDs); and children whose families are eligible for the State employee benefits plan.

Effective Date

oNo State is eligible for payments for child health assistance provided prior to October 1, 1997.

SUBTITLE J--STATE CHILDREN ’S HEALTH INSURANCE PROGRAM

Chapter 2--Expanded Coverage of Children Under Medicaid

Optional Use of State Child Health Assistance Funds for Enhanced Medicaid Match for Expanded Medicaid Eligibility (Section 4911)

Provisions

oStates may elect to use child health assistance funds to expand Medicaid eligibility. In order to receive funds to expand Medicaid eligibility, States must meet two conditions: (1) they must maintain their Medicaid eligibility at levels that are not more restrictive than those applied as of June 1, 1997; and (2) they must provide for reporting of information about expenditures relating to presumptive eligibility and to child health assistance provided to “optional targeted low-income children” under the expanded Medicaid program.

oStates that elect to the use the child health assistance funds to expand Medicaid eligibility and meet the two conditions described above will be eligible to receive an enhanced Medicaid match for “optional targeted low-income children.” The enhanced

Medicaid match is the State's current FMAP increased by 30 percent of the difference between 100 and the current FMAP.

oThe enhanced Medicaid match will apply to expenditures for "optional targeted low-income children." They are defined as targeted low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. It would not apply to expenditures for children below the poverty level who were born after September 30, 1983 as they age onto Medicaid under current law. If these expenditures exceed a State's allotment for the year (reduced by any expenditures for child health assistance paid to the State under the grant program), the State would receive only the regular FMAP, rather than an enhanced FMAP for the excess expenditures.

oThe enhanced Medicaid match also will apply to expenditures for children born before September 30, 1983 who are under age 19 and who are not eligible under the State Medicaid plan as of April 15, 1997.

Effective Date

oFor items and services furnished after October 1, 1997.

Medicaid Presumptive Eligibility for Low-Income Children (Section 4912)

Provisions

oStates are permitted under their Medicaid program to make medical assistance available to children under 19 during a presumptive eligibility period. The period begins with a date that a qualified entity determines, using preliminary information, that the family income does not exceed the income eligibility level; and the period ends with the earlier of an eligibility determination or, if an application for eligibility has not been filed, on the last day of the month following the month the entity makes the preliminary determination.

oThe term a "qualified entity" means an eligible provider under Medicaid or any entity authorized to determine eligibility for the Head Start program, the Child Care and Development Block Grant Act, or WIC. The Secretary may issue regulations further limiting qualified entities.

oA qualified entity must notify the State agency of the determination within 5 working days and inform the parent or custodian of the child and that an application is required to be filed by the end of the following month.

Effective Date

oUpon enactment.

Continuation of Medicaid Eligibility for Disabled Children Who Lose SSI Benefits (Section 4913)

Provision

oStates must continue Medicaid eligibility for disabled children who would have lost SSI benefits because of the change in the definition of childhood disability under the Personal Responsibility and Work Opportunity Act of 1996.

Effective Date

oJuly 1, 1997.

SUBTITLE J--STATE CHILDREN 'S HEALTH INSURANCE PROGRAM

Chapter 3--Diabetes Grant Programs

Special Diabetes Programs forType I Diabetes (Section 4921)

Provision

oThe Secretary must provide--directly or through grants--for research into the prevention and cure of Type I diabetes. Grants will be made available to children's hospitals, grantees under section 330 of the Public Health Service Act, and other Federally qualified health centers (FQHCs), State and local health departments and other public or non-profit private entities. For each of fiscal years 1998-2002, $30 million is transferred from title XXI for grants under this section.

Special Diabetes Programs for Indians (Section 4922)

Provision

oThe Secretary must make grants for the prevention and treatment of diabetes (for individuals of all ages) for services provided through the Indian Health Service (IHS), through an Indian health program operated by a tribe or tribal organization funded by IHS, or through an urban Indian health program funded by IHS. For each of fiscal years 1998-2002, $30 million must be transferred from title XXI for grants under this section.

Report on Diabetes Grant Programs (Section 4923)

Provision

oThe Secretary must conduct an evaluation of the diabetes grant programs in sections 4921 and 4922 and submit an interim report to Congress by January 1, 2000 and a final report by January 1, 2002.